PHYSICIAN RECERTIFICATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

APRIL 23, 1990

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PHYSICIAN RECERTIFICATION

MONDAY, APRIL 23, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 1:50 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 29, 1990

PRESS RELEASE #24
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
PHYSICIAN RECERTIFICATION

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on physician recertification. The hearing will be held on Monday, April 23, 1990, beginning at 1:30 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Physicians are now licensed for life. Recertification would require physicians to demonstrate periodically their continuing competence. By weeding out doctors who have lost their skills or failed to keep up with modern medical practice, we can begin to improve the quality of medical care and reduce the number of injuries. Improving the quality of practicing physicians must also be a major component of any response to the malpractice situation."

Mr. Stark will introduce a bill requiring periodic recertification prior to the hearing.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Any physician with a valid license to practice in a State is eligible to provide and bill Medicare for his or her services. The only exceptions are for physicians excluded from Medicare by the Secretary for fraud or abuse. Physicians may designate themselves as specialists to Medicare, whether or not they have had any special training or obtained a specialty certification.

Each State has statutes providing for physician licensure. All States require passing a standard licensing exam. All States recognize the Federation Licensing Examination (FLEX) offered by the Federation of State Medical Boards. Most States also accept the so-called "National Boards", prepared by the National Board of Medical Examiners and administered in three stages during the course of a student's education.

Physician licensure is generally for life. Physician licenses are not limited to specific areas of competence.

Although some States require renewal of a license, the physician is only required to submit certain documentation and is not required to demonstrate his or her competence. Some States require attendance at approved continuing medical education programs. However, those attending need not pass an exam or show any other evidence of accomplishment.

In addition to a license, many physicians obtain a credential known as "board certification." The American Board of Medical Specialties (ABMS) recognizes 23 specialty boards, including family practice, internal medicine, and surgery. Each specialty board establishes the requirements for certification. In addition to the ABMS member boards, there are other entities, usually called boards, that also provide for certain types of certifications.

Seventeen of the 23 ABMS member boards have approved the concept of recertification. Fourteen boards provide time-limited certification, ranging in length from seven to ten years. Fourteen boards require a written exam for recertification. However, most of these boards began offering time limited certificates only recently, and many others are just beginning to define the details of their policies. Most physicians certified prior to 1985 were given unlimited certificates and recertification will not be required.

Board certification is voluntary, has no relationship to medical licensure, and places no direct restrictions on the scope of a physician's practice.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, May 7, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The committee will commence its hearing. The Chair apologizes to the members and the guests and witnesses for the delay.

Today we are going to deal with the issue of physician recertification. I will ask that my opening statement be made a part of the record.

[The statement follows:]

OPENING STATEMENT OF HON. PETE STARK

Today's hearing addresses the important issue of assuring patients that their physicians have the knowledge and skills necessary to provide high quality medical care.

Life-long licenses and certifications offer little assurance of competence. Just because a physician was judged minimally competent 10 or 20 years ago has little bearing on whether he or she has maintained an adequate level of knowledge and skills.

To address this problem, I have introduced the Medicare Physician Qualification Act of 1990. This bill would improve the quality of care provided to Medicare beneficiaries by requiring that physicians treating Medicare patients pass a periodic examination of their competence as a condition of payment.

Patients cannot evaluate if their doctors have basic knowledge and skills. They rely on licensing boards and certifying organizations to make that judgment for them.

Currently, States have the authority and responsibility for licensing physicians. However, after receiving his or her initial license, a physician is never required to demonstrate that he or she has maintained the basic skills required for the practice of medicine.

States rarely remove or suspend a physician's license. In 1987, there were only 913 cases when a physician's license was revoked or suspended. While there has been some improvement in the system of medical discipline, less than two-tenths of 1 percent of practicing physicians were sanctioned in 1987.

One approach for assuring that physicians are qualified is to require periodic relicensing. After all, it is easier to deny an incompetent physician a new license, than it is to remove one.

While recredentialing or relicensing may sound radical, it is gaining support among physicians and regulators concerned about the quality of medical care.

After all, practicing medicine is not a right but a privilege. And it certainly is not unreasonable to expect that physicians should periodically demonstrate their qualifications as a condition for being granted that privilege.

The State of New York has taken the lead in developing and evaluating procedures for the periodic recredentialing of all physicians in that State.

In addition, periodic recertification policies have been adopted by all 23 of the member boards of the American Board of Medical Specialties.

In today's hearing, we will hear testimony describing these efforts from both the State of New York and the American Board of Medical Specialties.

Evaluating physicians' competence is not a simple task. There are many questions that have not been resolved. These include issues related to the accuracy of the testing process, what kind of tests or evaluations should be used, and who should be responsible for carrying out the evaluation process.

H.R. 4464 would allow ample time to address these issues. Under this bill, physicians would not be required to be recredentialed until 1996.

In addition, this bill encourages flexibility by providing that the Secretary may recognize valid State efforts to relicense their physicians on a periodic basis.

Assuring patients that their physicians are minimally competent should be a basic element of any quality assurance program.

I look forward to hearing from our witnesses on how we can provide assurance of competence through periodic evaluations of practicing physicians.

Chairman STARK. While there is a lot of agreement, I think that the public has to be reassured that there is proper screening and recertification of their physicians since most are incapable of making that decision for themselves. The difficult part is how to recertify. It may be one thing to certify a brand new physician who

has to have a broad knowledge of many factors of medicines. But after 20 years of specialization, does the physician forget about many of the general classifications having concentrated their practice on one specialty? Should they be required to have a broader knowledge?

Those are issues the professions have to grapple with. The basic issue to me seems to be this: as the system works now, those people who are reviewing physicians for competency and must penalize a physician who needs professional discipline are in the position of having to throw someone out. They are in the position of having to gather evidence and prove that a practitioner must be taken out of practice.

That has not happened very often. There have been a lot of lawsuits and retribution and problems of friendship and professional comity that make that difficult. It seems to me that period recertification wipes the slate clean and forces the practicing physician to prove to his peers that he or she is capable of continuing practice rather than the reverse which makes some panel of peers have to ferret out that person who may not be capable.

Whether that is the way the system ought to be changed or not is something that I hope our witnesses will be able to shed some light on.

I apologize for the lack of a speaker system. I think it may be with us momentarily. If the reporter can hear the witness and we can be quiet, perhaps we can get through this without the microphones.

I am pleased to welcome Dr. Alfred Gellhorn as our first witness. He has a distinguished career in both the academic and public sectors. As a past dean of the University of Pennsylvania School of Medicine, he is currently serving as the director of medical affairs in the New York State Department of Health. He has been recognized for his professional achievements with four honorary doctorate degrees. Most recently he has served as Commissioner of Recredentialing for New York State.

Dr. Gellhorn, New York State is to be commended for the leadership it has shown in this area. We welcome you to the committee. Your prepared statement will appear in the record in its entirety, without objection. Feel free to enlighten us in any manner in which you are comfortable.

STATEMENT OF ALFRED GELLHORN, M.D., DIRECTOR OF MEDICAL AFFAIRS, NEW YORK STATE DEPARTMENT OF HEALTH; AND CHAIRMAN, NEW YORK STATE ADVISORY COMMITTEE ON PERIODIC PHYSICIAN RECREDENTIALING

Dr. GELLHORN. Thank you Chairman Stark. Can you hear me all right? I am delighted to be here. I will attempt to go through a part of the testimony as quickly as possible although I am already getting intimidated by the Christmas lights in front of me. Nevertheless, I wish to start off by saying that in New York we are delighted that your committee is holding hearings on this subject. We feel, as do you, that here is a need on the part of the public to have reassurance with regard to the quality of medical care. Since 1985, the New York State Department of Health has been charged by

the legislature to monitor and improve the quality of care for hospitalized patients through mandatory reporting of events which are unexpected in the natural history of an illness, and reports by the hospitals' quality assurance committees with mechanisms designed to prevent future occurrences. An outgrowth of the overall program to maintain a high quality of medical care in the State was a public recommendation of Gov. Mario Cuomo in 1986 for periodic recredentialing of physicians for the license to practice medicine in New York.

Physician recredentialing was not greeted with enthusiasm by the medical profession, but there is a growing recognition that there is compelling evidence of widespread differences in the way physicians practice medicine, and that this leads to reasonable public concerns over quality of care. Abundant examples of overuse, underuse and inappropriate use of diagnostic and therapeutic procedures and medications have been reported in the medical literature in the nation and New York State. These I have documented in some detail in my testimony.

In New York the advisory committee on periodic physician recredentialing adopted the following principles: one, the process of recredentialing is to the educational, not punitive. If deficiencies are identified, appropriate remedial education is to be made available, not removal of the medical license.

Recredentialing will not only identify the poor performance of outlier, but is also designed to improve the average, and recognize the superior.

The standards of medical practice to be used in recredentialing will be defined and publicized widely, and the evaluation of the individual physician's compliance will be examined prospectively, not retrospectively.

The evaluations are to be done by peers.

There are to be several options for the recredentialing process.

Before formal implementation of recredentialing, there will be validation of the proposed processes.

The proposed periodic reeredentialing would be at 9-year intervals.

It is generally known by the medical profession that there are widespread differences in the way physicians manage a particular medial problem, and for many of these clinical problems a consensus has been developed by experts which indicates the appropriate way. So what is the issue? Experience has shown that knowledge of the appropriate standards of clinical practice is necessary but not sufficient to change physician behavior. Guidelines for practice may predispose physicians to consider changing behavior, but unless there are other incentives or the removal of disincentives, guidelines may be unlikely to effect rapid change in actual practice.

The current plans for recredentialing in New York will provide the incentive. Three options will be available. Major reliance will be vested in peer review of clinical guidelines, a euphemism for standards of practice, developed by the individual Special Specialty Societies. The guidelines reflect the current opinion of the particular specialists based on extensive review of the clinical literature as well as consensus development by expert panels. Importantly, the

guidelines are dynamic, subject to modification based on newer information derived from technology assessment and outcome measurements rather than static bureaucratic dicta. The guidelines developed by practicing specialists, often with participation of patients and purchasers, have credibility among doctors, which provides assurance of acceptance. Many of the academies and associations of specialists have already formulated practice guidelines and the remaining are being encouraged to develop their standards.

In New York, physicians may designate themselves as specialists whether certified or not by a specialty board. Regardless of specialty board status, all who self describe themselves as specialists will be held to the same standards of practice within their specialty. Compliance with the guidelines developed by a specialty society will be carried out by peers who will fulfill this obligation by patient record review and where indicated, by interview. A preliminary experiment is in progress to test this methodology. Analysis of cesarean section rates in New York revealed variation from 13 to 40 percent per 1,000 live births in various areas of the State and even in hospitals in the same community. These discrepant rates could not be rationalized on the basis of the presence or absence of high risk pregnancies. A joint committee of the American College of Obstetricians and Gynecologists and the State Department of Health developed a "dictionary," yet another euphemism for standards, of indications and measurement of outcomes for cesarean section. These were distributed to all ACOG members, all hospital obstetrical services and the relevant hospital chief executive officers. Now teams of board certified obstetricians, with evaluation training, are carrying out 2 day site visits of randomly selected hospitals show cesarean section rate varies widely. It is interesting that, at the outset there were many concerns regarding the liability potential, the confidentiality protection, and possible ambiguity in the standards. The feedback had indicated a strong interest and now requests from a number of facilities asking for peer review. The trial is at the halfway mark and it is too early to determine the total impact on physician behavior regarding cesarean section. Although we have some preliminary information. However, the peer evaluators report that the need for improvement was the rule rather than the exception. Other specialties which are poised to carry out trials of peer review of standards already developed by their national organizations include anesthesiology, psychiatry, and otorhinolaryngology. Discussions are in progress with the ophthalmologists, radiologists, neurosurgeons, and dermatologists. The American College of Physicians, New York Chapter, the Academy of Pediatrics, and the subspecialties of cardiology and gastroenterology have been approached, as well as the American College of Osteopathy.

Before discussing another option which will be made available in New York, I wish to emphasize the importance of peer reviewers to monitor compliance with specialty society guidelines of clinical practice. The professional review organizations mandated by Congress have given primary attention to control of resource utilization and implementation of prospective payment rather than quality of care. Physicians and hospitals view the relationship with PRO's as punitive and adversarial. Despite their inflammatory and

regulatory characteristics, the PRO's have had little influence on the quality of care, and their elimination would be hailed by doctors. Peer review of compliance with standards of practice will, I believe, be demonstrated to have a positive impact on quality of care. Also, doctors and hospitals would collaborate and cooperate more effectively.

A second method of recredentialing proposed in New York is specialty board recertification. There are three limitations of this method. The physicians who received their board certification prior to the date that time-limited certification was introduced are "grandfathered" and are not required to recertify to retain their board certification. Although voluntary recertification is available, it is unlikely that it would be elected by many. Another drawback is that 24 percent of the physicians in New York who designate themselves as specialists are not certified by a specialty board and in most instances are not eligible to take the requisite examinations. A final reservation about specialty board recertification is that the examinations are, for the most part, multiple choice questions. These test the cognitive knowledge of the examinee but provide no assurance that application of the knowledge in clinical practice will be appropriate.

There is one final group of physicians who do not fall into any of the above categories. These are retired physicians, such as myself, or those in administrative posts with no direct patient care responsibilities who, nevertheless, wish to maintain an active license to practice medicine. At the present time, the most likely recredentialing disposition which will be made available for this group is the SPEX examination which is prepared by the Federation of State Medical Licensing Boards.

In summary, New York State is now in the process of validating the feasibility of peer review of the compliance of physicians with standards of clinical practice developed by specialty societies. If the method is sustained by preliminary trial and gains the appropriate approvals, this will be the principal mechanism for periodic recredentialing. Specialty board recertification, office-record review to determine compliance with protocols in ambulatory medical problems, and a cognitive examination for physicians not in clinical practice are the other, less frequently applicable recredentialing methods.

It is recognized that no single approach or concept of quality assurance is likely to meet all requirements. The recredentialing proposed in New York does not deal with the art of medicine, that is the integrity, respect, and compassion of the physician which are critical to the humanistic care of patients. The recredentialing methodology does not deal directly with cost containment and it assumes that the appropriate process of care will lead to better end results of care. The recredentialing is only applicable to physicians and therefore does not test the quality of care provided by the myriad of other components of the health care system. It is hoped that the validation of the methodology which is now underway will demonstrate its feasibility and also gain acceptance by physicians.

Finally, it is noteworthy that the interest of this committee in physician accountability is an important asset to the efforts to de-

velop periodic recredentialing in New York, inasmuch as it confirms that the issue is of national as well as State concern.

Chairman STARK. Thank you, Dr. Gellhorn.

[The statement of Alfred Gellhorn, M.D. follows:]

Testimony Before the Subcommittee on Health
of the House Ways and Means Committee

Chairman: The Honorable Fortney Stark
Regarding HR 4464: Periodic Recertification of Physicians

Alfred Gellhorn, M.D. - Witness
Director of Medical Affairs
New York State Department of Health
Chairman of the New York State Advisory
Committee on Periodic Physician Recredentialing

Frustration, anger, resentment and clamor are among the reactions around discussions of a need to reform the health care system and to meet the requirements to improve quality, eliminate the inequities of access, and achieve these goals at a cost which is commensurate with the benefits. A comprehensive blueprint to solve these objectives is understandably not immediately apparent because of the often disparate interests of consumers, employees, health care providers, uninsured people, and those who pay the costs. Changes in the health care system, therefore, are occurring incrementally. The major emphasis has been on cost containment efforts such as the Prospective Payment Act of 1983, and the Resource Based Relative Value System for physician payment -- an initiative of this Subcommittee. Cost containment alone, however, must not be allowed to drive health policy. This is why we in New York State are encouraged that this Committee is directing its attention to the pressing health care concerns of the public regarding the issue of the quality of medical care. In this area your interest and that of New York State are closely joined.

Since 1985, the New York State Department of Health has been charged by the Legislature to monitor and improve the quality of care for hospitalized patients through mandatory reporting of adverse events which are unexpected in the natural history of an illness, and reports by the hospitals' quality assurance committees with mechanisms designed to prevent future occurrences. An outgrowth of the overall program to maintain a high quality of medical care in the state was a public recommendation of Governor Mario Cuomo in 1986 for periodic recredentialing of physicians for the license to practice medicine in New York.

Physician recredentialing was not greeted with enthusiasm by the medical profession, but there is a growing recognition that there is compelling evidence of widespread differences in the way physicians practice medicine, and that this leads to reasonable public concerns over quality of care. Abundant examples of overuse, underuse and inaopropriate use of diagnostic and therapeutic procedures and medications have been reported in the medical literature in the nation and in New York State.

More than 20 years ago, Wennberg called attention to overuse, as shown by the multifold variation in tonsillectomies and adenoidectomies in neighboring areas of Vermont despite very similar proportions of children. This type of analysis has been repeated by many: for example, Chassin's demonstration of inexplicable variation in coronary angiography in Saskatchewan. In New York, the variation in the age-adjusted rate of hysterectomy was more than three times higher in western counties of the state than in New York City. Inappropriate use is also too frequent. For example, it has been found in a review of antibiotic prescribing that in only 72 percent of cases were the therapeutic indications correct, and for prophylactic treatment, the indications were appropriate in only 36 percent. Review of 5,000 hospital records of Medicare patients by Chassin and Kosicoff led to the conclusion that the indications for carotid endocterectomies were inappropriate in 32 percent of the cases. Examples of underuse of available medical care has been shown for the elderly for treatable incontinence and depressions, and, distressingly, in too many children, in failure to immunize for common preventable diseases.

On the face of it, all agree that the initial license to practice medicine, a lifetime privilege, does not provide adequate assurance that the individual physician will maintain the needed knowledge and skills of advances in medical science. In view of the rapid growth in diagnostic

and therapeutic means, there is a pressing need to update the knowledge base. This has led 17 of the 23 Medical Specialty Boards to give time-limited certification to those who now pass the examinations, with recertification required at intervals ranging from 7 to 10 years to maintain the specialty board certificate. Another recognition of the attrition in medical knowledge is the expectation that all physicians would participate in continuing medical education either through individual study of medical journals or organized conferences and courses. Continuing medical education is undoubtedly valuable and necessary, but, in the absence of validation of the putative beneficial effect, this also fails to provide the necessary objective assurance that it prevents professional obsolescence. These facts, together with growing public sophistication, argue that physicians, like airline pilots who also make critical decisions affecting life and limb, have an obligation to provide periodic assurance that their knowledge base is current. It was to this end that the Governor requested the Commissioner of Health and the Chancellor of the Board of Regents to appoint an advisory committee on physician recredentialing.

The New York State Advisory Committee on Physician Recredentialing

The committee, appointed in the spring of 1987, had broad representation of medical practitioners, medical educators, public representation, members of the state medical society, national organizations involved in medical certification, and state government. At the outset, it was recognized that the charge to develop recredentialing for appropriate standards of medical practice is not synonymous with certification of medical competence. The latter concept describes a comprehensive quality which includes knowledge, skills, interpersonal relationships to patients, and mature judgment; there exist no tests which cover all of these qualities and capabilities. The recommendations for recredentialing in New York are a first approximation to an additional quality assurance mechanism in medicine, and include many, but not all of the identified components of competence.

Both implicit and explicit guidelines were adopted by the advisory committee:

- The process of recredentialing is to be educational, not punitive. If deficiencies are identified, appropriate remedial education is to be made available, not removal of the medical license.
- Recredentialing will not only identify the poor performance of outliers, but is also designed to improve the average, and recognize the superior.
- The standards of medical practice to be used in recredentialing will be defined and publicized widely, and the evaluation of the individual physician's compliance will be examined prospectively, not retrospectively.
- The evaluations are to be done by peers.
- There are to be several options for the recredentialing process.
- Before formal implementation of recredentialing, there will be validation of the proposed processes.
- The proposed periodic recredentialing would be at 9-year intervals.

The criteria for recredentialing are necessarily different from those which must be met at the time of initial medical licensure. For the latter it is appropriate to determine the cognitive knowledge of the applicant in the broad fields of biomedical science and clinical medicine. Subsequently, physicians differentiate into a variety of clinical disciplines and modes of activity to meet the health needs of the public. The recredentialing is not designed to determine the physician's knowledge of all aspects of medicine, but rather to determine whether his/her current practice meets appropriate standards.

The general mechanisms for recredentialing which have been proposed include peer review according to specified protocols, specialty board certification or recertification, and cognitive and clinical problem solving testing.

Since the initial formulation of the recredentialing process, there has been evolution of the planning based on pertinent national and state-generated evidence. As was indicated earlier, it is generally known by the medical profession that there are widespread differences in the way physicians manage a particular medical problem, and for many of these clinical problems a consensus has been developed by experts which indicates the appropriate way. So what is the issue? Experience has shown that knowledge of the appropriate standards of clinical practice is necessary but not sufficient to change physician behavior.

In a recent article, Lomas et all concluded "... that guidelines for practice may predispose physicians to consider changing behavior, but unless there are other incentives or the removal of disincentives, guidelines may be unlikely to effect rapid change in actual practice." This pragmatic conclusion was reached from a study in Ontario in which indications for cesarean section were widely disseminated, the obstetricians were aware of the recommendations and approved them. Data on actual practice after the publication of the guidelines showed only a slight change from the previous upward trend. Similar and disappointing behavior change have been reported on the management of high blood pressure and other issues on which professional consensus standards have been developed. In the State of Washington, 2,700 hospital records were reviewed to determine if the quality of care improved with regard to 12 recommendations on specific clinical problems reached by NIH consensus panels. The study extended from 24 months before to 13-24 months after each consensus conference. The target audience was reached with the information but overall physician behavior was unchanged.

On the other hand, Wennberg reported that when the Vermont Medical Society initiated peer review of the hospitals and physicians performing tonsillectomies and adenoidectomies to determine the basis for performing the operation, the rates fell dramatically. Similarly in Saskatchewan, peer review led to a significant reduction in hysterectomy rates. In New York State, a requirement was mandated that prescriptions for the tranquilizer drugs be made on a triplicate form, one copy of which was filed with the Department of Health. The knowledge by physicians, who were over-prescribing such drugs as valium, that their prescriptions were being monitored led to a 55 percent reduction in psychotropic drug prescribing in nursing homes and Medicaid mills within one year.

The Current Plans for Recredentialing in New York

In New York State, major reliance will be vested in peer review of clinical guidelines, a euphemism for standards of practice, developed by the individual Medical Specialty Societies. The guidelines reflect the current opinion of the particular specialists based on extensive review of the clinical literature as well as consensus development by expert panels. Importantly, the guidelines are dynamic, subject to modification based on newer information derived from technology assessment and outcome measurements rather than static bureaucratic dicta. The guidelines developed by practicing specialists, often with participation of patients and purchasers, have credibility among doctors, which provides assurance of acceptance. Many of the Academies and Associations of specialists have already formulated practice guidelines and the remaining are being encouraged to develop their standards.

It is recognized that the Office of the Forum for Quality and Effectiveness on Health Care of the HHS Agency for Health Care Policy and Research has been charged with the development of clinically relevant guidelines. I hope that these will be developed in conjunction with the Council of Medical Specialty Societies or other national organizations so that the recommendations will be consonant and credible.

In New York, physicians may designate themselves as specialists whether certified or not by a Specialty Board. Regardless of Specialty Board status, all who self describe themselves as specialists will be held to the same standards of practice within their specialty. Compliance with the guidelines developed by a Specialty Society will be carried out by peers who will fulfill this obligation by patient record review and, where indicated, by interview. A preliminary experiment is in progress to test this methodology. Analysis of cesarean section rates in New York revealed variation from 13 percent to 40 percent per 1,000 live births in various areas of the state and even in hospitals in the same community. These discrepant rates could not be rationalized on the basis of the presence or absence of high risk pregnancies. A joint committee of the American College of Obstetricians and Gynecologists and the State Department of Health developed a "dictionary," yet another euphemism for standards, of indications and measurement of outcomes for cesarean section. These were distributed to all ACOG members, all hospital obstetrical services and the relevant hospital Chief Executive Officers. Now teams of Board Certified obstetricians, with evaluation training, are carrying out two day site visits of randomly selected hospitals whose cesarean section rate varies widely. It is interesting that, at the outset there were many concerns regarding the liability potential, the confidentiality protection, and possible ambiguity in the standards. The feedback has indicated a strong interest and now requests from a number of facilities asking for peer review. The trial is at the half-way mark and it is too early to determine the impact on physician behavior regarding cesarean section. However, the peer evaluators report that the need for improvement was the rule rather than the exception. Other specialties which are poised to carry out trials of peer review of standards already developed by their national organizations include Anesthesiology, Psychiatry, and Otorhinolaryngology. Discussions are in progress with the Ophthalmologists, Radiologists, Neurosurgeons, and Dermatologists. The American College of Physicians (New York Chapter), the Academy of Pediatrics and the subspecialties of Cardiology and Gastroenterology have been approached, as well as the American College of Osteopathy.

Before discussing another option which will be made available in New York, I wish to emphasize the importance of peer reviewers to monitor compliance with Specialty Society guidelines of clinical practice. The Professional Review Organizations mandated by Congress have given primary attention to control of resource utilization and implementation of prospective payment rather than quality of care. Physicians and hospitals view the relationship with PRO's as punitive and adversarial. Despite their inflammatory and regulatory characteristics, the PRO's have had little influence on the quality of care, and their elimination would be hailed by doctors. Peer review of compliance with standards of practice will, I believe, be demonstrated to have a positive impact on quality of care. Also, doctors and hospitals would collaborate and cooperate more effectively.

A second method of recredentialing proposed in New York is Specialty Board Recertification. There are three limitations of this method. The physicians who received their Board Certification prior to the date that time-limited certification was introduced are "grandfathered" and are not required to recertify to retain their Board Certification. Although voluntary recertification is available, it is unlikely that it would be elected by many. Another drawback is that 24 percent of the physicians in New York who designate themselves as specialists are not certified by a Specialty Board and in most instances are not eligible to take the requisite examinations. A final reservation about specialty board recertification is that the examinations are, for the most part, multiple choice questions. These test the cognitive knowledge of the examinee but provide no assurance that application of the knowledge in clinical practice will be appropriate.

Peer review of practice guidelines or standards will be applicable to the majority of physicians who admit patients to hospitals. In New York, 17.5 percent of physicians are not on a hospital's staff. These may be specialists such as dermatologists, allergists, and psychiatrists who have no need for hospitalization of patients, and peer review of their records according to specialty standards will constitute the mechanisms for recredentialing. For solo practitioners, those in Medicaid group practices or HMO's, a protocol for office review of patient records has been developed which will have guidelines for the appropriate diagnosis,

treatment and follow-up of common medical problems in adult medicine and pediatrics. The compliance with these standards will also be monitored by peers.

There is one final group of physicians who do not fall into any of the above categories. These are retired physicians or those in administrative posts with no direct patient care responsibilities who, nevertheless, wish to maintain an active license to practice medicine. At the present time, the most likely recredentialing disposition which will be made available for this group is the SPEX examination which is prepared by the Federation of State Medical Licensing Boards.

In summary, New York State is now in the process of validating the feasibility of peer review of the compliance of physicians with standards of clinical practice developed by specialty societies. If the method is sustained by preliminary trial and gains the appropriate approvals, this will be the principal mechanism for periodic recredentialing. Specialty Board Recertification, office-record review to determine compliance with protocols in ambulatory medical problems, and a cognitive examination for physicians not in clinical practice are the other, less frequently applicable recredentialing methods.

It is recognized that no single approach or concept of quality assurance is likely to meet all requirements. The recredentialing proposed in New York does not deal with the art of medicine, that is the integrity, respect, and compassion of the physician which are critical to the humanistic care of patients. The recredentialing methodology does not deal directly with cost containment and it assumes that the appropriate process of care will lead to better end results of care. The recredentialing is only applicable to physicians and therefore does not test the quality of care provided by the myriad of other components of the health care system. It is hoped that the validation of the methodology which is now underway will demonstrate its feasibility and also gain acceptance by physicians.

Finally it is noteworthy that the interest of this Committee in physician accountability is an important asset to the efforts to develop periodic recredentialing in New York, inasmuch as it confirms that the issue is of national as well as state concern.

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Dr. Gellhorn, has your recertification program been actively enforced?

Dr. GELLHORN. We are in the process of validating the methodology, Mr. Pickle.

Mr. PICKLE. You don't have any real history, then, as to whether this program will work or is satisfactory.

Dr. GELLHORN. Well, there is abundant evidence in the literature that this type of process is effective. May I just cite two examples?

The evidence that this is an effective method has been demonstrated. A Dr. Wendburg was the first to call attention to the sevenfold variation in tonsillectomies in the State of Vermont, although the children were the same. When the State medical society began peer review the rate fell within a year on that procedure by more than fivefold. Also in our State the prescription of tranquilizer drugs which are the most frequently prescribed not only in New York but elsewhere, and there was introduced in New York a form of peer review in the requirement for a triplicate prescription.

One of the copies of this physician's prescriptions was filed with the State. When doctors who were over prescribing recognized that it would be on the record, the rate of prescribing of these drugs fell 55 percent in 6 months particularly in the Medicaid mills and in nursing homes.

So this and other evidences indicate that if there is surveillance of the knowledge that is available, that it has a profound effect on the behavior of physicians.

Mr. PICKLE. Doctor, how would a physician from another State coming into New York be recertified or certified? Is there a certain recognition of a certification from another State or would a doctor from Texas have to be recertified in New York?

Dr. GELLHORN. A physician coming into the State would fall into the situation that in an appropriate period of time recredentialing would be required. At the present time if that individual has been recently recertified by his specialty, that would count toward that. Otherwise, if not, the time clock would start immediately upon entry into New York for the process of recredentialing.

Mr. PICKLE. What does your plan do about a physician who is in New York and is practicing now? Would he have to be recertified or are they all grandfathered?

Dr. GELLHORN. There is no grandfathering at all. My colleagues in medicine have asked whether I would have to be recredentialed and the answer is, yes, everybody would have to be.

Mr. PICKLE. So the physicians in New York who had been practicing for 3 years would have to be recertified?

Dr. GELLHORN. If he was board certified his period for recertification would be not until 9 years later.

Mr. PICKLE. You have a plan. You passed it. Is it in effect yet?

Dr. GELLHORN. No. It is in the process of being tested.

Mr. PICKLE. Thank you very much.

Chairman STARK. Doctor, you suggest that your recredentialing would be education and not punitive. Is there a light at the end of the tunnel which you can turn off?

Dr. GELLHORN. Yes, certainly.

Chairman STARK. This is not just a matter of studying until you get back in touch.

Dr. GELLHORN. No, obviously not. It is entirely possible that this will identify practices which are unacceptable but we have mechanism for such situations in New York. The case goes before the office of professional conduct. Similarly, an individual who has been found wanting has a period of educational enhancement and it does not take—after a time that individual also will be excluded. It is not immediately a punitive thing but an educational one.

Chairman STARK. But the person must be able to continue to practice.

Dr. GELLHORN. That is right. They will be reexamined at an appropriate interval after.

Chairman STARK. What is SPEX?

Dr. GELLHORN. An examination by the Federation of State Medical Boards which is analogous to the FLEX which has been used for the initial license to practice medicine. It has been developed because a number of States require that a physician moving from one State to another State must pass an examination. This is called the SPEX examination.

It is for somebody who has been out for a period of time, but it is not as detailed in the basic sciences as the FLEX examination.

Chairman STARK. It would take into account somebody who left for politics, in the Senate for a couple of terms and then decided to come back and practice medicine and earn an honest living.

Dr. GELLHORN. That is right. I will take the SPEX examination.

Chairman STARK. Can you give us any insight into Governor Cuomo's interest in raising this issue? Was there a relationship? I am curious as to what relationship there is to the malpractice issue in the State of New York and also what the reaction has been in the physician community and perhaps the community at large.

Can you give us some of the political insights as to the results of the Governor's program?

Dr. GELLHORN. Yes. Mr. Cuomo has not shared this with me, I wish you to understand. But certainly the malpractice issue is very critical. It is the feeling of many of us to change the current tort system into something such as a form of no-fault or workmen's compensation will not be possible unless the public is reassured with regard to the quality of medical care. So I believe that is an important aspect of that.

With regard to the reaction of the medical profession, it is not enthusiastic, but it is a gradual recognition and inasmuch as the American Medical Association is now developing guidelines of practice, that HCFA asked the Institute of Medicine to work on this and the Council of Medical Societies which Dr. Wilbur leads is very actively pursuing this in all specialties. There is an active recognition that this is the way medicine should move in the future.

Chairman STARK. Doctor, thank you. I want to repeat to you and to the other witnesses my apology for being tardy and getting these hearings started late and also to my colleagues and our guests for the lack of a PA system, which hopefully will be working soon. Thank you, sir.

Our next panel includes three witnesses representing groups involved in the licensing and credentialing of physicians: Dr. Peyton Weary, president, American Board of Medical Specialties, Dr. James Winn, executive vice president, Federation of State Medical Boards, and Dr. Richard Wilbur, executive vice president, Council on Medical Specialty Societies testifying on behalf of American Medico-Legal Foundation.

Gentlemen, we will try to hear you. If you want to direct any expansion of your remarks toward the reporter, that would be appreciated. You may proceed in any manner you are comfortable. Dr. Weary, do you want to begin?

STATEMENT OF PEYTON E. WEARY, M.D., PRESIDENT, AMERICAN BOARD OF MEDICAL SPECIALTIES, AND PROFESSOR AND CHAIRMAN, DEPARTMENT OF DERMATOLOGY, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE

Dr. WEARY. I will try to speak loudly, I am recovering from an upper respiratory infection and I hope my voice will hold out.

I am Peyton E. Weary, M.D., professor and chairman of the Department of Dermatology at the University of Virginia School of Medicine, and president of the American Board of Medical Specialties. I am presenting this testimony on behalf of the American Board of Medical Specialties, ABMS, which is the umbrella organization of the 23 specialty certifying boards representing all of the major disciplines of specialty medicine.

All 23 ABMS boards have since 1973 endorsed the principle of periodic recertification. At the present time 19 boards have defined plans to recertify their diplomates and 17 boards now issue, or soon will issue, only time-limited certificates which are valid for periods ranging from 7 to 10 years. Certificates issued prior to the imposition of time-limited certification are considered to be valid for life. Both initial certification and recertification are voluntary. Physicians who either choose not to be certified, or fail to be certified for various reasons, may practice specialty medicine provided they are licensed to practice medicine. Furthermore, physicians who are not certified by an ABMS member board may call themselves a specialist. At the present time there are, in addition to the 23 specialty boards recognized by ABMS, 112 self-designated boards which are not recognized by the ABMS and the AMA. These self-designated boards are highly variable in their requirements when compared with the members of ABMS. Such boards may apply for membership and a few have submitted formal requests to the Liaison Committee for Specialty Boards, LCSB, for review. Only those who meet the rigorous ABMS requirements for training, experience, and examination will be recommended for membership.

We have reviewed draft legislation entitled "Medicare Physician Qualification Act of 1990" which your subcommittee has prepared and wish to comment about the proposed legislation as follows:

As noted above, all of the ABMS member boards are committed to the concept of the need for continuing assessment of performance and the desirability of periodic voluntary recredentialing as a method of providing continuing assurance to the public that the recredentialed specialist has maintained an acceptable level of quali-

fications. However, just as initial certification was voluntary, it has been axiomatic that recertification would be voluntary and not linked to any punitive sanction or limitations on reimbursement. We do support the use of the AMBS recertification process believing this is a high standard well above a minimum standard. What this legislation proposes is more akin to periodic relicensure since it would apply to all physicians certified and not certified.

I would like to point out one potentially serious consequence of this legislation. that is the possibility that it may create access problems for Medicare beneficiaries in some communities because some physicians may choose not to be examined and others may fail to be qualified after examination.

We believe the possibility of limitation on access deserves careful analysis before enactment and would propose a study of this issue by the GAO. We believe there must be a system of remediation and provisional approval pending reexamination for those failing to qualify. We also note that traditionally licensure and relicensure have been State prerogatives. We would hope that Federal legislation would not preempt State and local initiatives such as peer review, practice audit and hospital credentialing as appropriate mechanisms for evaluation of performance.

We believe State and local initiatives need more, rather than less, encouragement and support. We note that ABMS member boards cannot recertify physicians who have not been certified initially and acknowledge the fact that this would necessitate the creation of a two-tiered examination process, recertification for those certified and a separate process for the approximately one-third of American physicians who are not currently certified by ABMS member boards.

The appropriate legislation calls for a general practice examination for the noncertified physicians. We would direct your attention to the fact that such an examination would only be appropriate for one segment of noncertified physicians. Many noncertified physicians actually specialize and such a general examination would not be appropriate for many of these individuals. Furthermore a general examination would not evaluate the knowledge of specialized areas which these individuals would be expected to comprehend. Thus, specific specialty examinations should be created for such individuals.

In our testimony we have outlined what we believe are some general principles that should be incorporated in any process of periodic recredentialing. We believe the proposed legislation should specify both remediation and provisional approval pending reexamination and should have provisions for the creation of specialty specific examinations for noncertified specialists. We are pleased to note that recertification by ABMS member boards is one reason to qualify.

I believe that ABMS member boards would apply to the secretary and be very likely be approved. We believe if the legislation encourages States to become more active in appropriate recredentialing of physicians, it will serve a very useful function. We hope that rather than preempting State responsibilities, it would strengthen State initiatives and encourage local evaluative processes. We would once again emphasize the need for a careful analysis

of the impact of this legislation on access for Medicare patients to physicians.

Thank you very much.

Chairman STARK. Thank you.

[The statement and attachments of Peyton E. Weary, M.D. follow:]

Statement of Peyton E. Weary, M.D.
President, American Board of Medical Specialties

Mr. Chairman, I am Peyton E. Weary, M.D., Professor and Chairman of the Department of Dermatology at the University of Virginia School of Medicine, and President of the American Board of Medical Specialties. I am presenting this testimony on behalf of the American Board of Medical Specialties (ABMS) which is the umbrella organization of the 23 specialty certifying Boards representing all of the major disciplines of specialty medicine. These 23 certifying Boards issue 31 general specialty certificates and 57 subspecialty certificates. The 23 certifying Boards of ABMS function "to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation process, including an examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality patient care in the specialty."

With respect to recertification, there is one important inaccuracy to be noted in the announcement of this hearing. All 23 ABMS Boards have since 1973 endorsed the principle of recertification. At the present time 19 Boards have defined plans to recertify their diplomates and 17 Boards now issue (or soon will issue) only time-limited certificates which are valid for periods ranging from 7-10 years. Certificates issued prior to the imposition of time-limited certification are considered to be valid for life. Both initial certification and recertification are voluntary. Physicians who either choose not to be certified, or fail to be certified for various reasons, may practice specialty medicine provided they are licensed to practice medicine. Furthermore, physicians who are not certified by an ABMS Member Board may call themselves a "specialist." At the present time there are, in addition to the 23 specialty boards recognized by ABMS, 112 self-designated boards which are not recognized by the ABMS and the AMA. These self-designated boards are highly variable in their requirements when compared with the members of ABMS. Such boards may apply for membership and a few have submitted formal requests to the Liaison Committee for Specialty Boards (LCSB) for review. Only those who meet the rigorous ABMS requirements for training, experience and examination will be recommended for membership.

We have reviewed draft legislation entitled "Medicare Physician Qualification Act of 1990" which your subcommittee has prepared and wish to comment about the proposed legislation as follows:

1. As noted above, all of the ABMS Member Boards are committed to the concept of the need for continuing assessment of performance and the desirability of periodic voluntary recredentialing as a method of providing continuing assurance to the public that the recredentialed specialist has maintained an acceptable level of qualifications. However, just as initial certification was voluntary, it has been axiomatic that recertification would be voluntary and not linked to any punitive sanction or limitations on reimbursement. On the other hand, medical licensure is a mandatory standard adopted by the states and is a sine qua non for the practice of medicine. The legislation which you propose would clearly be more appropriately termed relicensure rather than recertification because it imposes the sanction of failure to reimburse under Medicare for services performed by non-conforming physicians. We would certainly agree with the proposal to use recertification by an ABMS Member Board as one mechanism of compliance with the provisions set forth. We believe that recertification by an ABMS Member Board is a high standard, well above a level of minimum qualifications and for that reason we anticipate such recertification will be deemed as most acceptable by the Secretary and I would anticipate that ABMS Member Boards will request such qualification.

2. We would direct your attention to one potentially serious consequence of the proposed legislation which must be of great concern. It is possible that some physicians may elect to forego Medicare participation rather than submit to examination. It is also possible that some physicians will fail to qualify on examination. Depending upon the extent to which the above statements are valid, there may arise serious problems of access for Medicare patients in some communities in the United States. It is clear that there must be some system of remediation and reasonable flexibility such as provisional approval pending re-examination to address these concerns. The decision as to whether this is the most appropriate method to assure maintenance of qualifications is basically a political one, rather than a professional decision. We would suggest that an analysis of the potential impact of this legislation upon the limitation of access to physician services for Medicare patients might be a worthy project for the General Accounting Office.

3. The proposed legislation basically sets forth a program for periodic relicensure of physicians. In this respect it may conflict with proposals for periodic relicensure under consideration by several states, including New York State. It is important to note that licensure and relicensure have traditionally been the prerogatives of the states. It is likely that this legislation may be perceived by some as an initial effort to shift the focus of licensure and relicensure to a federal system and this may be of concern to those who believe that licensure and relicensure are best accomplished at a state level where peer review and sanctions against unqualified physicians are thought to be more valid and immediate.

   We are pleased to note that the Secretary may deem state licensure programs acceptable if periodic licensure with examination is enforced.

   We would commend for your careful analysis the proposals for periodic relicensure under consideration by New York State. These proposals are considered by some as having been carefully constructed to provide maximum flexibility and may in time serve as a model for other states. Having recently heard an address by Dr. Alfred Gellhorn who heads the State Commission charged with implementing this plan, I can tell you that the Commission is moving with deliberate speed to develop an appropriate program for periodic relicensure. This proposal is receiving very careful attention by a number of professional organizations.

   I would direct your attention to the fact that recertification by ABMS Member Boards is one of the major pathways approved for relicensure by the Commission. The New York State proposal would also endorse periodic hospital recredentialing or practice audit as appropriate pathways for compliance. We believe that such alternate options have much merit because their focus is more related to performance and outcomes assessment than simply a cognitive examination process. A number of ABMS Member Boards incorporate practice audit of one type or another in their recertification process in addition to a cognitive examination in the belief that this provides an appropriate dimension which enhances the predictive validity of the recertification process. It is our understanding that New York State is also exploring the applicability of other peer review mechanisms to their relicensure process and is also aware of the need for remediation as an essential component.

We believe it would be most unfortunate were federal relicensure requirements to preempt innovative concepts under consideration by the states since diversity encourages innovation and improvements in the system. ABMS has consistently supported and encouraged innovation in evaluative procedures.

We also believe that were any federal system to be imposed, it would be highly desirable for there to be enough flexibility in the system to preclude imposing an arbitrary 7-year cycle upon a state, such as New York State which proposes to have a 9-year cycle.

4. ABMS cannot accept responsibility for preparing examinations for physicians who are not previously certified. We acknowledge the necessity for the creation of a two-tiered system of recredentialing. Approximately one-third of physicians in the United States are currently not certified by an ABMS Member Board. ABMS recently sponsored a conference to analyze the roles and activities of non-certified specialists. We believe the number of non-certified physicians is gradually diminishing, although it will never be zero. Such individuals are not able to be recertified since they were never certified in the first place and hence would be forced to take a general practice examination developed by the Secretary. In the absence of alternative pathways such as proposed by New York State or because of lack of availability of state re-licensure alternatives, it might be predicted that a large number of non-certified physicians might be compelled to sit for a uniform general practice examination. We believe this is not practical or desirable for the following reasons:

Many non-certified physicians limit their practice to highly specialized areas even though they are not certified specialists. Many of these specialized areas of practice are far removed from general medical practice and hence such individuals would not be expected to have appropriate experience in the type of medical practice for which a general practice examination would be constructed. To test these individuals on information they would not routinely utilize nor would be expected to have is not justifiable. Likewise, a general practice examination would of necessity be deficient in questions related to areas of specialty medicine which those who limit their practice to those areas would be expected to know. Thus we would be testing such individuals inappropriately. There would thus be a need to develop specialty-specific examinations for the major specialty areas for those physicians who are not certified.

In summary, we feel the following are general principles for periodic recredentialing of physicians:

1. Recredentialing can be accomplished by recertification by an ABMS or AOA Board with approval by the Secretary.

2. Recredentialing can be accomplished by relicensure with required examination or other evaluative process adopted by a state licensing board with approval by the Secretary.

3. States may adopt various methods to relicense subject to reasonable standards set by the Secretary. In setting standards, the Secretary should create an environment which will provide flexibility, encourage innovation, and promote remediation. State relicensure may be based on one of the following:

a. Recertification by an ABMS or AOA Board; or

b. Evaluation of practice (peer review) by the organized medical staff of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations or some other appropriate method of peer reviewed practice audit conforming to general standards approved by the Secretary; or

c. Passage of a general cognitive examination process offered by a recognized national testing agency such as the National Board of Medical Examiners or its osteopathic equivalent; or

d. Passage of an appropriate specialty-specific cognitive examination process offered by a recognized national testing agency or created by a state licensing agency. In creating specialty-specific examinations it may be appropriate to solicit assistance from national specialty societies.

4. Any system of recredentialing should include provisions for remediation and provisional approval for those who fail, pending successful re-examination within a specified period of time.

5. The decision to link periodic recredentialing to medical reimbursement is a political decision that should only be made with full awareness that it may create problems for some Medicare beneficiaries in securing access to physicians. Before the decision is made, the possible impact upon access deserves careful and objective analysis.

Thank you for the opportunity to comment on this important issue.

APPENDICES: LCSB Requirements for Approval and
List of Self-Designated Boards

AMERICAN BOARD OF MEDICAL SPECIALTIES
One Rotary Center, Suite 805 Evanston, Illinois 60201-4889 312/491-9091

April 9, 1990

Members
American Board of Allergy & Immunology
American Board of Anesthesiology
American Board of Colon & Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Practice
American Board of Internal Medicine
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics & Gynecology
American Board of Ophthalmology
American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine and Rehabilitation
American Board of Plastic Surgery
American Board of Preventive Medicine
American Board of Psychiatry & Neurology
American Board of Radiology
American Board of Surgery
American Board of Thoracic Surgery
American Board of Urology

Associate Members
American Hospital Association
American Medical Association
Association of American Medical Colleges
Council of Medical Specialty Societies
Federation of State Medical Boards of U.S.
National Board of Medical Examiners

Public Members
Gerard Piel
W. Ann Reynolds, Ph.D.

Officers-Executives
Committee 1988-89
Robert B. King, M.D.
President
Peyton E. Weary, M.D.
President-Elect
Lee J. Dunn, M.D.
Treasurer
Donald T. Erwin, M.D.
Laurence Finberg, M.D.
Elliott L. Mancall, M.D.
Ike Muslow, M.D.
Frank C. Wilson, M.D.
Paul R. Young, M.D.

Staff
Donald G. Langsley, M.D.
Executive Vice President
Barbara K. Kremer, Ph.D.
Director of Research
Alexis L. Rodgers
Director of Operations
Margaret F. Kruly
Coordinator of Publications

SELF-DESIGNATED BOARDS

Information exists in the ABMS files on the following self-designated boards. They are called "American Board of _____" unless otherwise designated, and each purports to certify physicians.

Abdominal Surgeons
Acupuncture Medicine
Addiction Medicine
Addictionology
Adolescent Psychiatry
Aesthetic Plastic Surgery
Alcoholism & Other Drug Dependencies (AMSAODD)
Algology (Chronic Pain)
Alternative Medicine
Ambulatory Anesthesia
Anthroscopy
Arthroscopic Surgery
Bariatric Medicine
Bionic Psychology
Bloodless Medicine & Surgery
Cardiac Catheterization and Angiography
Chelation Therapy
Chemical Dependence
Clinical Chemistry
Clinical Ecology
Clinical Neurology
Clinical Neurophysiology
Clinical Neurosurgery
Clinical Nutrition
Clinical Orthopaedic Surgery
Clinical Pharmacology
Clinical Polysomnography
Clinical Psychiatry
Clinical Psychology
Clinical Toxicology
Cosmetic Plastic Surgery
Cosmetic Surgery
Council of Non-Board Certified Physicians
Critical Care in Medicine & Surgery
Dermalogy
Disability Evaluating Physicians
Electrodiagnostic Medicine
Electroencephalography
Electromyography and Electrodiagnosis
Environmental Medicine
Epidemiology (College)
Facial Cosmetic Surgery
Facial Plastic Surgery
Forensic Psychiatry
Forensic Toxicology
Hand Surgery
Head, Facial & Neck Pain & TMJ Orthopedics
Health Physics
Homeopathic Physicians
Homeotherapeutics
Hypnotic Anesthesiology, National Board for
Industrial Medicine & Surgery
Insurance Medicine
Int'l. Cosmetic & Plastic Facial Reconstr. Stds.
Interventional Radiology
Laser Surgery
Law in Medicine
Malpractice Physicians
Maxillofacial Surgeons
Medical Accreditation (American Federation for)
Medical Genetics
Medical Hypnosis
Medical Laboratory Immunology
Medical-Legal Analysis of Medicine & Surgery

Medical Legal & Workers Compensation Medicine & Surgery
Medical Legal Consultants
Medical Microbiology
Medical Preventics (Academy)
Medical Toxicology
Medical Psychotherapists
Microbiology (Medical Microbiology)
Military Medicine
Neurologic & Orthopaedic Dental Medicine & Surgery
Neurological & Orthopaedic Medicine
Neurological & Orthopaedic Surgery
Neurological Microsurgery
Neurology
Neuro-Orthop. Dental Medicine & Surgery
Neuro-Orthop Electrodiagnosis
Neuro-Orthop. Laser Surgery
Neuro-Orthop. Psychiatry
Neuro-Orthop. Thor. Medicine/Surgery
Nutrition
Orthopaedic Microneurosurgery
Otorhinolaryngology
Pain Management (American Academy of)
Pain Management Specialties
Pain Medicine
Percutaneous Diskectomy
Plastic Esthetic Surgeons
Prison Medicine
Psychiatric Medicine
Psychiatry (American National Board of)
Psychoanlaysis (American Examining Board in)
Psychological Medicine (International)
Quality Assurance and Utilization Review
Radiology and Medical Imaging
Rheumatologic Surgery
Rheumatological and Reconstructive Medicine
Ringside Medicine & Surgery
Skin Specialists
Spinal Cord Injury
Spinal Surgery
Sports Medicine
Sports-Medicine/Surgery
Toxicology
Trauma Surgery
Traumatologic Medicine & Surgery
Tropical Medicine
Ultrasound Technology
Urologic Allied Health Professionals
Weight Reduction Medicine

Total - 112

DGL/bh/2

TENTH REVISION OF ESSENTIALS FOR APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Approved by ABMS September, 1986 and by AMA December, 1986

Section I. **Function of the Liaison Committee for Specialty Boards (LCSB).**

The American Board of Medical Specialties (ABMS), by authority of its member boards and other member organizations, and the American Medical Association Council on Medical Education (AMA/CME), by authority delegated by the AMA House of Delegates, have established the LCSB consisting of four representatives selected from each body. The Chairman of the AMA/CME shall be the Chairman of the LCSB. The Executive Vice President of the ABMS shall be the Secretary of the LCSB but shall not vote. The Secretary of the AMA/CME shall attend meetings of the LCSB but shall not vote.

The purpose of the Liaison Committee is:

A. To receive applications for approval of medical specialty boards and make recommendations to its parent bodies.

B. To provide a mechanism for contact with petitioning groups through the Secretary of the LCSB on matters related to approval of new specialty boards and for transmission of decisions of the ABMS and AMA/CME to applicants.

C. To determine as expeditiously as possible if the applicant board has complied with the Essentials for approval.

To assist in attaining these objectives, the LCSB is authorized to appoint consultants known to the ABMS and the AMA/CME to be qualified and knowledgeable in the special field which the new specialty board intends to represent.

Section II. **Definition of a Specialty Board.**

A specialty board is a separately incorporated, financially independent body which determines its requirements and policies for certification, selects the members of its governing body in accordance with the procedures stipulated in its bylaws, accepts its candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit to and pass its evaluations.

Section III. **Objectives and Functions of Specialty Boards.**

A fundamental objective of all approved boards is to act in the public interest by contributing to the improvement of medical care by establishing the qualifications for candidates and by evaluating individuals who apply for certification.

The primary function of all approved specialty boards is to evaluate the qualifications of candidates who apply and to certify as Diplomates those who are found to be qualified.

To accomplish this function, specialty boards shall:

A. Determine whether or not candidates have received adequate preparation in accord with educational standards established by the specialty board.

B. Conduct comprehensive evaluations of the knowledge and experience of such candidates, and

C. Issue certificates to those physicians found qualified under the stated requirements of the board.

A related function of approved specialty boards is to assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in collaboration with other concerned organizations and agencies.

Section IV. **Criteria for Approval of New Examining Boards.**

A. The establishment of a new specialty board signifies the differentiation of a new specialty which must be based on major new concepts in medical science.

B. A new medical specialty board must represent a distinct and well defined field of medical practice. It may entail special concern with the problems of patients according to age, sex, or organ systems or with the interaction between patients and their environment.

A new certifying board must be based on substantial advancement in medical science. The needed training must be sufficently complex or extended that it is not feasible to include it in established training programs.

C. A board must require evidence that its diplomates have acquired capability in a stated area of medicine and will demonstrate special knowledge in that field.

D. A plan must be presented whereby preparatory programs in graduate medical education will be developed for accreditation by the Accreditation Council for Graduate Medical Education (ACGME). New boards may be permitted under conditions stated by the petitioning board and approved by the LCSB, to approve training or experience or a combination of both as equivalent to that acquired in accredited training programs until accreditation by the ACGME is in place.

E. The applicant must present satisfactory evidence that the proposed board has broad professional support in the specialty, and that approval will promote and enhance recognition of a single standard of preparation for practice in each specialty.

F. In order to promote public and professional understanding and recognition of a single standard in each specialty and to promote efficiency of the evaluation process, only one certifying board will be recognized in each specialty.

G. While it is recognized that considerable variation among certifying boards may be permitted, the operational plan must include satisfactory details in the following areas:

(1) Names, professional affiliations and professional accomplishments of the sponsors.

(2) Structure—the composition of the board should provide for representation of appropriate organizations and for effective operation of the board.

(3) Content of the field—data from a detailed analysis of the professional area, including present and future public needs and professional interests should be presented. Such analysis should be used for development and continued evaluation of standards for certification.

(4) While requirements may not be fully developed at the date of application, a plan for development and validation of the requirements should be presented.

(5) A detailed plan for evaluating individual candidates should be presented.

(6) The financial support for a valid, objective program of candidate evaluation, as well as other necessary activities in graduate education must be included in the plan. The data presented should include projected numbers of potential diplomates and projected certification fees.

Section V. **Procedure for Approval of New Specialty Boards.**

A. The application should be directed to the Secretary of the LCSB who also serves as Executive Vice President of the ABMS.

B. The LCSB may conduct a hearing before making a recommendation on any application.

C. The application should adhere to the following outline:

(1) The name of the proposed specialty board asking for approval.

(2) The proposed objectives and function of the petitioning board.

(3) The names of the sponsoring organizations.

(4) A detailed statement describing how compliance with each of the criteria in Section IV is achieved.

(5) A description of the proposed organization, the names and professional qualifications of the proposed officials, the names and addresses of the founding members, their qualifications, and the organization which each member represents.

(6) A copy of the proposed or existing Constitution and Bylaws.

(7) A copy of the proposed or existing Articles of Incorporation.

(8) An outline of the qualifications to be required of applicants for certification.

(9) The number and names of institutions providing residency or other acceptable training programs in the specialty, the total number of residencies available, and the number of residency training programs that can be developed.

(10) The approximate number of physicians engaged in the practice of the specialty.

(11) A copy of the proposed application form for candidates for certification.

(12) Provisions, if any, for certifying physicians practicing in the specialty without examination or accredited training. The statement should include the qualifications and the number of physicians to be certified in that manner.

D. The responsibility of the LCSB is not limited to initial evaluation of the certifying boards in medical specialties. Proposed changes in policy which differ substantially from those policies and procedures which prevailed at the time of approval should be reported to the Secretary of the LCSB for transmittal to the LCSB for action as required.

E. The LCSB shall submit a report and recommendations to the ABMS and the AMA/CME for consideration by their members within one year after receipt of the application.

F. The ABMS and the AMA/CME shall independently act on the application after receiving a recommendation for approval from the LCSB. An affirmative vote of two-thirds of the members of each of the ABMS and the AMA/CME, present and voting provided a quorum is present, is required to approve the new board. Each parent of the LCSB shall report its action to the Secretary of the LCSB. If one of the parents disapproves, it must transmit the reasons for disapproval to the LCSB.

G. If possible, within twelve months of receipt of the application as defined in Section V.C., the LCSB shall inform the petitioning group of their decision. If the decision is negative the petitioner may request reconsideration by the LCSB which could include an opportunity for the petitioner to be heard in person. Following reconsideration by the LCSB, the provisions of Section V.F. will apply. The LCSB will then transmit the final action of the parents of the LCSB, after reconsideration, to the petitioner.

H. The petitioner may file a formal appeal in the event of a negative decision in the reconsideration process. This will be initiated by a request for an appeal to the Secretary of the LCSB who will transmit that information to the ABMS and the AMA/CME. The appeal will be heard by a five-person panel consisting of two members of the ABMS Executive Committee who are *not* members of the LCSB (appointed by the ABMS Executive Committee) and two members of the AMA/CME who are *not* members of the LCSB (appointed by the AMA/CME). These four individuals will chose a "public member" who may not be a member of the ABMS or the AMA/CME. The appeals panel will hear the appeal of the petitioner and would then transmit its recommendations to the LCSB. After considering the recommendations of the appeals panel, the LCSB will take final action on the appeal and will notify both the petitioners and the parents of the LCSB.

I. Following approval by the LCSB, ABMS, and AMA/CME, the board shall not issue new certificates to individuals who received certification prior to approval without requiring that each meet the same requirements as candidates applying for board certification after approval.

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Section VI. **Meetings of the LCSB.**

The LCSB shall meet at least annually at the call of the Chairman. On petition of five members of the LCSB, the Chairman shall call a special meeting. The Chairman may also call a special meeting to conduct any business which comes to the attention of the Secretary of the LCSB.

Section VII. **Amendments or Revisions of the Essentials for Approval of Examining Boards in Medical Specialties.**

Amendments or revisions of the Essentials must be approved by the ABMS and the AMA House of Delegates. Those amendments or revisions which have been approved by two-thirds of the LCSB shall be transmitted by the Secretary to these parent groups for consideration and vote. Changes in the Essentials shall take effect on approval of both the ABMS and the AMA House of Delegates.

APPROVAL OF EXAMINING BOARDS IN MEDICAL SPECIALTIES

Since 1934, medical specialty boards have been officially approved by action of the American Board of Medical Specialties (ABMS) and the American Medical Association Council on Medical Education (AMA/CME). This determination begins with review by the Liaison Committee for Specialty Boards (LCSB), an organization sponsored by the AMA/CME and the ABMS.

The LCSB consists of four voting representatives from the ABMS Executive Committee and four voting representatives from the AMA/CME. The Chairman of the AMA/CME serves as Chairman of the LCSB. The Executive Vice President of the ABMS serves as Secretary of the LCSB (without vote). The Secretary of the AMA/CME also serves on the LCSB (without vote). The LCSB meets on the call of the Chairman at no fixed intervals, but generally meets annually.

The functions of the LCSB are:

1) to receive applications for approval as a medical specialty certifying board.
2) to evaluate applications according to the current version of the "Essentials for Approval of Examining Boards in Medical Specialties."
3) to hold hearings on such applications if appropriate to do so.
4) to have the Secretary forward approved applications to the sponsors of the LCSB (the ABMS and the AMA) along with the recommendations of the LCSB. Both the AMA/CME and the ABMS must act affirmatively by a ⅔ majority if a new board is to be approved. LCSB is not required to ratify the actions of its sponsors.
5) to notify the applicant of the action of the sponsors of LCSB. If the application is disapproved, the applicant may reapply after 12 months.

Action on applications for approval of examining boards in medical specialties is based on the *Essentials for Approval of Examining Boards in Medical Specialties*, a collaborative effort of the ABMS and the AMA/CME begun in 1934. The original *Essentials for Approval of Examining Boards in Medical Specialties* was based on recommendations of the ABMS Committee on Standards and Examinations and was approved by the AMA House of Delegates in June, 1934. The *Essentials* have undergone several revisions, both major and minor, since 1934. The present, tenth revision of the *Essentials* is a joint document approved by both organizations. It embodies the policies of both the ABMS and the AMA pertaining to specialty boards while retaining each organization's privilege of independent consideration and action. The *Essentials* describe the standards and procedures by which applications for approval of new examining boards are evaluated.

The approved specialty boards and the current list of categories of certification in each of those specialties are listed on the inside front cover of this edition of the *ABMS Annual Report and Reference Handbook*.

STATEMENT OF JAMES R. WINN, M.D., EXECUTIVE VICE PRESIDENT, FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

Chairman STARK. Dr. Winn.

Dr. WINN. Thank you.

I am Dr. James Winn, executive vice president of the Federation of State Medical Boards of the United States. I appreciate the opportunity to share with you today the views of the federation relative to a number of issues raised by H.R. 4464, the Medicare Physician Qualification Act of 1990. I would like to begin, Mr. Chairman, by complimenting both you and the members of this committee for your sincere concern for quality medical care.

The bill under discussion today is clearly motivated by that concern. Those of us who have served on and worked with State medical boards appreciate possibly better than any other group the importance of this issue.

As you know, in this country the duty and responsibility for medical licensure resides in the individual States. We who function within that system and strive to make it as effective as possible feel our obligations very deeply.

However, the bill before you today could well be seen by most States as a from of Federal medical licensure. Although prompted by the best of intentions it could easily be the prelude to a national licensing system. The authority that this legislation would give to the Secretary of the Department of Health and Human Services who approve State license reregistration systems, what this bill calls relicensure would be based on standards mandated by Congress and would in effect put an end to the power exercised by the people of the States acting through their legislatures to establish those systems that they believe would best protect their interests.

It would certainly lead to nationally mandated standards for licensure. Even if such standards relate technically only to Medicare and Medicaid, they will affect all medical licensing, for no States could realistically operate two distinct relicensing systems. The concern of the federation is with the medical boards, the physicians and people of the States.

I am submitting materials for inclusion in the record of these hearings that describe a concept of license reregistration that does not focus on testing all physicians over the years but builds rather on information generated every day reflecting physician performance and behavior. This places attention where it belongs, on the problem physician. The system is based on mandatory reporting to boards by health professionals, health care institutions, liability insurance carriers, courts and law enforcement agencies and by other appropriate organizations.

This mandatory reporting is complemented by a biannual self reporting program that requires the licensee to report to the board all adverse information about himself during the licensing period. At the same time the profile is updated revealing changes or patterns of change. Taken together mandatory reporting and self reporting permits the board, operating as they all do with finite resources, to concentrate their time and effort on markers or indicators of possible problems.

Today most States are moving toward such a system. This system of license reregistration which I have described could have greater impact if professional review organizations were mandated to communicate more effectively and promptly with State medical boards. Peer review organizations are currently funded to evaluate the quality of care rendered to Medicare patients. As a result of their quality assurance review, PRO's identify those physicians who are deemed to have a substantial number of quality issues in a substantial number of cases and subsequently institute corrective action plans for the physicians so identified. State licensing agencies should be promptly notified of all physicians who have been identified as requiring corrective action in order to establish an effective monitoring plan by the medical board. State medical boards could then institute appropriate action of the remedial efforts of the PRO are ineffective, or if the physician attempts to avoid review by relinquishing his participation in Medicare.

Here then, is an area where Federal legislation is appropriate and needed. The Congress can and should establish parameters for mandatory reporting to the boards by PRO's. I would urge you to concentrate on such an effort as soon as possible. Effective reporting by the PRO's may not develop without your specific mandate. I believe the commendable purpose that motivated the bill you are reviewing today would be far better served by enhancing the reporting responsibilities of PRO's, already existing and funded agencies, than by creating what would be, in fact, a national licensing system for Federal health programs. The States are doing their job better each year. Appropriate action by Congress in this area would assist them in doing it still more effectively.

Beyond these points, this bill raised other serious concerns. I cannot elaborate on all of them, but let me mention several for your consideration. What would a State board do when it learned that one of its licensees had failed an examination approved by the Secretary, whether given by the secretary, by another State, or by a specialty board? Should it act against the licensee? Should it hold a hearing or give its own test? Would such a failure even be a violation of the State medical practice act? On the other hand, what if a licensee passed an examination approved by the secretary but failed a separate State examination? Could the State act in the face of the licensee's claim to have satisfied Federal standards? Whose examination standards would prevail? What would happen when a physician who passed the federally approved examination was identified as a possible problem by a PRO or a State reregistration system? Would the very diversity of methods for demonstrating qualification and fitness be discriminatory in itself?

As much as we admire your purpose and understand your concerns, we do not believe this legislation will achieve what you hope to achieve. In fact, we believe it could radically change the nature of licensure in the United States, damage progressive and worthwhile efforts in the States, and significantly alter the voluntary special board system. Worst of all, in the end, it could take licensure away from the people of the States, the people it is intended to protect and to whom it should be most accountable.

I urge you not to approve this bill but to support the States in their responsible efforts to identify unqualified, unfit, and impaired

physicians. Enhance and fund the quality review activities of the PRO's and mandate their reporting to the boards. Focus the energy and resources we have available on the problem physician.

Should you elect to ask the Physician Payment Review Commission to prepare a report on the evaluation of physician competence, a subject that has been and is being studied throughout the medical community, I hope you would submit the results to the States and their State medical boards for consideration rather than propose Federal legislation. Allow those who bear the responsibility for licensure to assess the information. Meanwhile, the federation would be pleased to report to you at appropriate intervals on the progress being made in enhancing and refining the licensing and disciplinary process.

Unfortunately, there are no legislative magic wands, either State or Federal, with which we can wave away the challenges that face us or conjure perfect solutions. We are dealing, after all, with human beings functioning in human systems and limited by human knowledge and experience. Working together, however, in our appropriate roles, with the commitment and concern that motivates us all, the States and their medical boards, the Federal Government, and the medical community can realistically address the issue of quality care. Dr. Oliver Wendell Holmes once wrote that "the great thing in this world is not so much where we stand, as in what direction we are moving". I believe we have been moving in the right direction and that this particular legislation may well be pointing the wrong way.

Thank you.

Chairman STARK. Thank you.

[The statement and attachments of James R. Winn, M.D. follow:]

James R. Winn, M.D.

Executive Vice President

Federation of State Medical Boards of the United States, Inc.

H.R. 4464 TESTIMONY

Good afternoon, Mr Chairman and members of the Committee. I am James R. Winn, MD, Executive Vice President of the Federation of State Medical Boards of the United States. Founded in 1912, the Federation is the national voluntary association of state medical boards, both allopathic and osteopathic, and is comprised of sixty-six member boards. The Canadian provincial medical licensing authorities hold affiliate membership in the Federation as well. The Federation is a parent and member organization of the National Board of Medical Examiners, the Educational Commission for Foreign Medical Graduates, the Accreditation Council for Continuing Medical Education, and the American Board of Medical Specialties. It also maintains liaison with major medical organizations in the United States and with the medical licensing authorities of several foreign countries.

Through its FLEX Board and in cooperation with the National Board of Medical Examiners, the Federation structures and conducts the Federation Licensing Examination (FLEX), the test instrument for medical licensure used by all states and several other jurisdictions. In early 1988, the Federation introduced the Special Purpose Examination (SPEX), a test instrument designed to assist boards in assessing the qualifications of candidates for licensure by endorsement who have not been examined for some years. A complete computer record of FLEX and SPEX scores, along with appropriate biographical information on examinees, is maintained by the Federation.

Today the Federation and the National Board of Medical Examiners are cooperating in the development of the United States Medical Licensing Examination, a three step test instrument that will provide, for the first time, a single examination program for medical licensure. As a result, within a few years, all eligible candidates for medical licensure will sit the same examination sequence. This will be a major accomplishment in medical licensure in this country, a step thought almost impossible not many years ago.

The Federation also operates the nationally-recognized Board Action Data Bank, the preeminent system for collecting, recording, and distributing to state medical boards and appropriate agencies data on disciplinary actions taken against licensees by the boards and other governmental authorities, including the military and the Department of Health and Human Services. In the past six years, 550,000 inquiries have been processed by the data bank. In 1988 and 1989, the Federation developed and implemented the Direct Access System (DAS), a program for allowing secure on-line access to the Board Action Data Bank by state medical boards and other authorized users. The Board Action Data Bank is the most sophisticated and reliable resource of its kind. It has effectively assured that no board-sanctioned licensee can move within the medical system undetected.

Along with its other activities, the Federation collects and publishes the most complete information available on physician licensing and disciplinary boards and maintains a resource library of the various practice acts and rules under which its member boards operate. That library is the only central collection of such material in the country. The Federation also offers the states and the boards specific policy recommendations related to medical licensure and discipline. Those recommendations are actively promoted in several publications, such as the Guide to the Essentials of a Modern Medical Practice Act and the Model for the Preparation of a Guidebook on Medical Discipline. The Federation's educational activities include its Annual Meeting and publication of the monthly Federation Bulletin, the quarterly FSMB Newsletter, and the biennial Exchange. The Federation Bulletin, by the way, is the world's only journal devoted exclusively to medical licensure and discipline. Under federal contract, we have also developed and disseminated the Elements of a Modern State Medical Board, designed to encourage boards to review and assess the effectiveness of their structure and function.

The Federation, as I believe you can see, is the national clearinghouse, forum, and representative body for state medical boards. It occupies a unique position of responsibility in relation to its member boards and the people of the states they are charged to serve. It makes and will continue to make significant contributions to the effectiveness and integrity of the medical licensing and disciplinary systems that are essential components of medical quality in the United States.

For your information, I have attached to these prepared remarks copies of the Federation publications I have mentioned.

I deeply appreciate this opportunity to share with you the views of the Federation relative to a number of issues raised by H.R. 4464, the Medicare Physician Qualification Act of 1990.

I would like to begin, Mr. Chairman, by complimenting you and the members of this Committee on your sincere concern for quality medical care. The bill before you is clearly motivated by that concern. Those of us who have served on and work with state medical boards appreciate, possibly better than any other group, the importance of this issue. Based on our real and sometimes painful day-to-day experience, we recognize the need to assure the qualifications and fitness of licensed physicians in an effective and practical way.

As you know, in this country, the duty and responsibility for medical licensure resides in the states. We who function within that pluralistic system and strive to make it as effective as possible feel our obligations deeply. We are always pleased to find support for our efforts and a recognition of our problems in the halls of Congress.

That said, however, the bill before you today could well be seen by most states and by state medical boards as a form of federal medical licensure. Prompted by the best of intentions, it could easily be the prelude to and precedent for a national licensing system that would mark the end of state authority in this area, moving the licensing process further away from the people of the states it is intended to protect and to whom it is now accountable.

The authority this legislation would give the Secretary of the Department of Health and Human Services to approve state license reregistration systems (what the bill calls relicensure), based on standards mandated by Congress, would, in effect, put an end to the power exercised by the people of the states, acting through their legislatures, to establish those systems they believe would best protect their interests.

One of the strongest elements of our state-based pluralistic licensing structure is the flexibility it allows the people of the states to develop and test a variety of approaches to the problems facing all boards. From the oversight of residency training to initial licensure, from license reregistration to disciplinary process, improvements have been dramatic over the past two decades, thanks in many ways to the power of the states to seek better approaches to meeting their responsibilities. Creation of a national approval mechanism, with all that implies now and for the future, would inevitably cripple the creative flexibility inherent in our pluralistic system. It would certainly lead to nationally mandated standards for all areas of licensing activity. Even if such standards relate, technically, only to Medicare -- and later Medicaid -- they must affect all medical licensing, for no state could realistically wish to operate two distinctly separate licensing systems.

It would be ironic if so well-intentioned a piece of legislation as HR 4464 led to the end of a system that has come so far in its effort to protect the public interest in the context of state authority.

I should also mention that I am concerned by the implications of the power the bill would give the Secretary to approve the examinations of voluntary specialty boards. In the long term, I cannot help but think such power could make federal authority controlling in the determination of specialties. The nature of the examination must influence the nature of the specialty. Does the federal government

really wish to assume that responsibility? It may be on the road to doing so.

My concern, of course, is with the medical boards, the position of the states, and the people of the states. I am presenting materials to you today for inclusion in the record that describe a concept of license reregistration that is not focused on the testing of all physicians every few years. It centers, instead, on the steadily improving identification of unqualified, unfit, and impaired physicians. Building on information that is generated every day reflecting physician performance and behavior, it places attention where it belongs -- on the problem physician. It does not propose elaborate and costly systems for attempting to determine the competence of each individual physician -- a task, by the way, that may not be possible in a practical sense. The system is based on mandatory reporting to boards by health professionals, health care institutions, liability insurance carriers, courts and law enforcement agencies, professional and specialty organizations, specified state agencies, and others. This mandatory reporting is complemented by an annual or biennial self-reporting program requiring the licensee to report to the board all relevant adverse information about himself or herself that may have developed during the reregistration period. At the same time, the licensee's professional profile (practice location, specialty, professional memberships, hospital privileges, CME activities, licenses held, etc.) is updated, allowing a review of sudden changes or patterns of change. Taken together, mandatory reporting and self-reporting permit a board, operating as all do with finite resources, to concentrate time and effort on markers and indicators of possible problems -- red flags for board attention and potential board action.

Today, most states are moving to such a system. Data accompanying the material I have made available for the record will provide you a clear idea of the progress that has been made over the past several years.

The system of license reregistration I have described could have still more impact if professional review organizations were mandated to communicate more effectively and promptly with state medical boards. Peer review organizations are currently funded to evaluate the quality of care rendered to Medicare patients. As a result of their quality assurance review, PRO's identify those physicians who are deemed to have a substantial number of quality issues in a substantial number of cases and subsequently institute corrective action plans for the physicians so identified. State licensing agencies should be promptly notified of all physicians who have been identified as requiring corrective action in order to establish an effective monitoring plan by the medical board. State medical boards could then institute appropriate action if the remedial efforts of the PRO are ineffective, or if the physician attempt to avoid review by relinquishing his participation in Medicare.

Here is an area where federal legislation is appropriate and needed. The Congress can establish parameters for mandatory reporting to the boards by PROs. I would urge you to concentrate on such an effort as soon as possible. Effective reporting by the PROs may not develop without your specific mandate. I believe the commendable purpose that motivated the bill you are reviewing today would be far better served by enhancing the reporting responsibilities of PROs, already existing and funded agencies, than by creating what would be, in fact, a national licensing system for federal health programs. The states are doing their job better each year. Appropriate action by Congress in this area would assist them in doing it still more effectively.

Beyond these points, this bill raises other serious concerns. I cannot elaborate all of them, but let me mention several for your consideration. What would a state board do when it learned one of its licensees had failed an examination approved by the Secretary, whether given by the secretary, by another state, or by a specialty board? Should it act against the licensee? Should it hold a hearing or give its own test? Would such a failure even be a violation of the state medical practice act? On the other hand, what if a licensee passed an

examination approved by the Secretary but failed a separate state examination? Could the state act in the face of the licensee's claim to have satisfied federal standards? Whose examination standards would prevail? What would happen when a physician who passed the federally-approved examination was identified as a possible problem by a PRO or a state reregistration system? Should a physician pass a federally approved specialty examination to practice in a specialty for Medicare reimbursement? Should states, therefore, license by specialty? Would the very diversity of methods for demonstrating qualification and fitness be discriminatory in itself?

As much as we admire your purpose and understand your concerns, we do not believe this legislation will achieve what you hope to achieve. In fact, we believe it could radically change the nature of licensure in the United States, damage progressive and worthwhile efforts in the states, and significantly alter the voluntary specialty board system. Worst of all, in the end, it could take licensure away from the people of the states, the people it is intended to protect and to whom it should be most accountable.

I urge you not to approve this bill but to support the states in their responsible efforts to identify unqualified, unfit, and impaired physicians. Enhance and fund the quality review activities of the PROs and mandate their reporting to the boards. Focus the energy and resources we have available on the problem physician.

Should you elect to ask the Physician Payment Review Commission to prepare a report on the evaluation of physician competence, a subject that has been and is being studied throughout the medical community, I hope you would submit the results to the states and state medical boards for consideration rather than propose federal legislation. Allow those who bear the responsibility for licensure to assess the information. Meanwhile, the Federation would be pleased to report to you at appropriate intervals on the progress being made in enhancing and refining the licensing and disciplinary process.

Unfortunately, there are no legislative magic wands, either state or federal, with which we can wave away the challenges that face us or conjure perfect solutions. We are dealing, after all, with human beings functioning in human systems and limited by human knowledge and experience. Working together, however, in our appropriate roles, with the commitment and concern that motivates us all, the states and their medical boards, the federal government, and the medical community can realistically address the issue of quality care. Dr. Oliver Wendell Holmes once wrote that "the great thing in this world is not so much where we stand, as in what direction we are moving." I believe we have been moving in the right direction and that this particular legislation may well be pointing the wrong way.

Thank you.

CONCENTRATING ON THE PROBLEM PHYSICIAN:

Perspectives in Medical Discipline

DALE G BREADEN

Introduction

"The price one pays for pursing any profession," wrote the American essayist James Baldwin, "is an intimate knowledge of its ugly side."

We have come together today to share our thoughts, experiences, and insights regarding a significant aspect of the ugly side of medicine. Each of us, physician and non-physician, brings a different perspective to the process, of course, and I should like to begin by giving you some idea of mine and by introducing you to the organization I have had the privilege of serving as associate executive vice president for the past seven years.

The Federation

As you are aware, medical licensure or registration in the United States is a power reserved to the states. It is not a national responsibility, though I can assure you there are those who would use any excuse to make it so. (Everyone knows what a remarkably efficient job centralized national bureaucracies do in providing even the simplest services.) Each of the states has developed its approach to the regulation of medicine independently and in keeping with its sense of public need. This diversity has allowed a steady, if uneven, evolution of the regulatory process over the years of this century, significant improvements made in one state spreading to others over

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Delivered in Adelaide, Australia, as the keynote address for a two day seminar on the *Identification and Management of Professional Incompetence — Assistance for the Distressed Doctor*. Sponsored by the Australian Medical Council (AMC), the Medical Board of South Australia, and the South Australian Postgraduate Medical Association, the seminar was held on June 18 and 19, 1988, at the Medical School of the University of Adelaide. Mr. Breaden, associate executive vice president of the Federation of State Medical Boards, was in Australia for three weeks as a guest of the AMC visiting state medical boards and various medical organizations and attending the AMC's Annual General Meeting.

Though the word physician has a more restricted meaning in Australia (and several other English speaking countries) than in the United States, it is used here in its broad sense to include all medical practitioners. — DGB

Mr. Breaden's presentation has been divided into two parts for publication in the BULLETIN. This segment describes the current status of medical licensure in the United States. In the somewhat longer second part in the March BULLETIN, Mr. Breaden will discuss the "remedy," various facets of the regulation of medical practice in this country. — Ed.

time. This creative pluralism, inherent in the federal structure, while incomprehensible to the mind of the centralizer, has been one of the most dynamic strengths of the medical licensing system in the United States. At any one moment, improvement is occurring at some point within the system and influencing other parts of it. Change, for good or ill, is being constantly tested. At the same time, the pluralistic system has been a protection against the potentially stultifying effect of regulation dominated by a single national entity, keeping control of licensure close to the people it is intended to protect. Even Dante, I fear, could not imagine or describe the licensing system that might be devised by the Congress of the United States.

Mr. Breaden

While recognizing the importance of diversity in the regulation of medical practice, since the 1890s the states have also recognized the value of voluntary cooperation amongst themselves and have sought to bring some degree of unity to their regulatory efforts. The National Confederation of State Medical Examining and Licensing Boards was established in 1891 and the American Confederation of Reciprocating Examining and Licensing Boards in 1902: two different associations of state medical boards with somewhat different missions. In 1912, these two organizations merged to form the Federation of State Medical Boards of the United States, a non-governmental, non-profit, self-supporting voluntary association of all state medical boards. As a result, a truly national approach to interaction was adopted, combining the strengths of independent state authority with the virtues of shared national experience.

Prior to the establishment of the Federation, its two parent organizations, through various reports and recommendations, influenced the unification of preliminary medical education, prompted general adoption of full high school training as a requirement for medical school admission (which grew into the premedical college requirement), had a bearing on unifying courses of study in medical schools, encouraged a standard medical cur-

riculum, and urged at least minimum equipment for all medical college departments.

Medical licensure, in the current understanding of the term, did not emerge in the United States until 1873 and 1874 when the states of Texas and Kentucky established the earliest modern state medical boards. By 1895, all states had licensing laws and twenty-two required a diploma and an examination. In 1910, the Flexner Report, a study confirming the inadequacy of a great many American medical schools, also exposed the weaknesses of many medical boards and called for their rapid improvement. The groundwork was well prepared, therefore, for the voluntary creation of the Federation in 1912.

From 1915 to 1961, remarkable as that may seem, Walter L. Bierring, M.D., one of the most distinguished figures in American medicine, was secretary-treasurer of the Federation and editor of its BULLETIN, which, by the way, is seventy-five years old this year and is the only monthly journal devoted exclusively to issues of medical licensure and discipline. As late as 1956, Sir Walter, as he was called, was actively pointing out the need for improved "methods of determining fitness for licensure and the practice of medicine as distinguished from those required for graduation from an approved school or college of medicine." For over seventy-five years, the Federation has attempted to address that need and to improve those methods.

The Federation's membership comprises sixty-five jurisdictions: the medical boards of all the states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands, and eleven of the sixteen independent state boards of osteopathic medicine. All the members of these boards are fellows of the Federation and many of them have been and are prominent in the affairs of numerous major medical organizations. Along with board members, the executive directors of the member boards, men and women committed to quality medical practice, are deeply involved in Federation activities. The ten Canadian provincial medical licensing authorities and the Federated States of Micronesia medical licensing board hold affiliate membership in the Federation.

The Federation is a parent and member organization of the National Board of Medical Examiners, the Educational Commission for Foreign Medical Graduates, and the Accreditation Council for Continuing Medical Education. It was a founding member of what was to become the American Board of Medical Specialties and remains an associate member of that body today. It also sits on the board of the National Commission on Certification of Physician Assistants. To perform its tasks effectively, it

maintains valuable and constructive relationships with a variety of professional, licensing, and certifying organizations: the American Medical Association, the Association of American Medical Colleges, the American Osteopathic Association, other national medical groups, national organizations of licensing and certifying agencies in health related fields, and medical licensing or registration authorities in several foreign countries.

The Federation, through its FLEX Board and in cooperation with the National Board of Medical Examiners (NBME), structures and conducts the Federation Licensing Examination (FLEX), the test instrument for medical licensure that is used by all states and a number of other jurisdictions and that is, along with the NBME examination sequence, one of the two examination pathways to licensure in the United States. It is also the Federation's major source of revenue. Initiated in 1968 as a derivative of the NBME examination sequence, weighted to emphasize clinical areas and regularly updated, the FLEX was completely revised as of 1985, becoming a non-derivative, clinically based, and precisely focused licensing examination unrelated to academic achievement examinations. Discussion is now going forward on development of a uniform licensing examination pathway, combining the strengths of the FLEX and NBME examinations. Not too many years ago, such a unifying step would not have been imagined possible. In addition, the Federation introduced this year the Special Purpose Examination (SPEX), a clinically based test instrument designed to assist boards in assessing the qualifications of candidates for licensure by endorsement/reciprocity who have not been formally examined for some years.

The Federation maintains a complete computer record of FLEX scores and significant biographic information on all examinees, facilitating the process of endorsement/reciprocity amongst the states. It also operates the nationally recognized Physician Disciplinary Data Bank, the preeminent system for collecting, recording, and distributing to state medical boards and appropriate agencies data on disciplinary actions taken against licensees by the boards and other governmental authorities. Over 2,300 such actions were reported in the past year. The Department of Defense makes similar information available to the Federation concerning physicians in the military. The Department of Health and Human Services reports data relating to Medicare/Medicaid sanctions.

The Federation annually collects and publishes the most complete information available on medical licensing and disciplinary

boards in the United States, including their licensing requirements and disciplinary functions. It also maintains a resource library of the various practice acts and regulations under which its member boards operate. Publications issued by the Federation include the monthly FEDERATION BULLETIN, the quarterly *FSMB Newsletter*, the annual EXCHANGE, the annual *Federation Handbook*, *A Guide to the Essentials of a Modern Medical Practice Act*, and *A Model for the Preparation of a Guidebook on Medical Discipline*. It also publishes a brochure on the Physician Disciplinary Data Bank, a pamphlet on FLEX, and a test preparation booklet for the FLEX.

As the clearinghouse, forum, and representative body for state medical boards, then, the Federation, with no legal authority of any kind, occupies a unique position of public responsibility. At the direction of its member boards and on behalf of the people they serve, it makes significant contributions to the effectiveness and integrity of the medical licensing and discipline systems in the United States, both of which are essential components of medical quality.

In doing this, the Federation is committed to four primary goals:

1. to assist its member boards and the people they serve in assuring the fundamental professional qualifications of licensed physicians;

2. to act as the national clearinghouse and resource center on all aspects of medical licensure and discipline for its member boards and, when required, for other interested or affected parties;

3. to provide appropriate forums and publications on medical licensure, discipline, and related issues; and

4. to represent and promote the interests of its member boards and the people they serve in and before local, state, regional, national, and international bodies affected by or affecting the boards, medical licensure, and medical discipline.

In approaching its responsibilities and pursuing its goals, the Federation's course is determined by certain essential concepts it believes provide a sound foundation for the regulation of medical practice.

A. The practice of medicine is a privilege granted by the people acting through their elected representatives. It is not a natural right of individuals.

B. In the interest of public health, safety, and welfare, and to protect the public from the unprofessional, improper, and incompetent practice of medicine, it is necessary to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

C. The primary responsibility and obligation of a medical board is to protect the public.

With this being understood as my particular vantage point, let me turn to our concern here today: that ugly side of medicine. In doing so, I hasten to add, I am fully aware there are more good questions than good answers; and I do not pretend to many, if any, answers. But I solace myself with James Thurber's remark: "It is better to know some of the questions than all of the answers." An occasional answer would, of course, be useful! But I can only provide some perspectives on our experiences in the Federation and on approaches developing among our member boards. If they suggest some possible answers, all to the good. If they raise tougher questions, well, that is good, too: maybe better. Tougher questions will surely lead in time to better answers.

Current Scene

It may seem a profound irony that in the closing decades of the twentieth century, in the face of the remarkable accomplishments and incredible potential of medicine, there is, simultaneously, a growing emphasis on questions of professional incompetence and impairment. Yet more surprising, I think, would be the absence of such concern in view of the ever-increasing complexity of medical science and its essential role in modern life.

You know far better than I that there are those moments when the practicing physician has an unbidden consultant named Death who hovers at his or her shoulder; and that a missed diagnosis, an erring treatment, a failure to refer, a neglected follow-up, a mistake, brightens that spectre's unblinking eyes. Fortunately, the unbidden consultant is usually put off. Most patients will survive the human errors all physicians will occasionally make. A few will not. Certainly, our grim consultant is greedy and wants his portion sooner rather than later. And he is there, I suspect, more often than one knows, awaiting his due.

Add to that image a physician who is incompetent, negligent, impaired, or unfit. Such a physician, knowingly or unknowingly, dances to the spectre's tune. The patient is at needless risk and the very idea of medicine is betrayed.

Over the past fifteen or twenty years, we have become more acutely aware of this reality and of the obligation medicine owes itself and the public to identify those who forsake the duty of professionalism and service, for whatever reason, and those who enter medicine unprepared or unfit, either through deceit or the inadequacy of the system itself: those who are physicians in name but not in fact.

This is not to say that medicine has come awake unprodded or has been converted by a sudden vision on the road to Damascus. It has, rather, reacted in part to the

ever more insistent pressure of a public become more demanding and knowledgeable than it has ever been. And with quite good reason. Society now spends huge sums on health care: close to 12% of the gross national product in the United States, where $83 billion was expended on Medicare alone last year to provide care for 28 million elderly and 3 million disabled Americans, where four workers support one Medicare beneficiary today and only two will do so by the year 2000, where the Medicare trust fund may well be exhausted within fifty years, and where, despite Medicare for the elderly and Medicaid for the poor, and billions spent on private health insurance by individuals and business, over 30 million citizens have no medical protection at all. Needless to say, accountability is expected as much or more from medicine as from any other segment of society. And this public demand, I suspect, is hardly unique to the United States. Stimulated by consumer interest groups, government, private insurance firms, business, labor, and the media, the people of the world's wealthiest nations are coming to recognize that health care is their biggest single business. And the physician is, finally, the key to the success or failure of the enterprise in relation to the individual's welfare. If his or her skill cannot be relied upon, the rest is so much humbug.

A facet of this increasing insistence on accountability is the professional liability problem that has grown like a cancer through the body of American medicine

Touring the Wine Country of South Australia. **(From left) Dr. Bernard J. Amos, president, Medical Board of New South Wales, Australia; Mrs. Dale Breaden; Mr. Breaden; and Mr. John W. Kilpatrick, secretary, Australian Medical Council.**

in the past two decades and, I understand, manifests itself in varying degrees in the other leading nations of the world. But it is well to remember that physicians are not alone. Tort actions in the United States, for example, often based on the most outlandish claims of injury, spring from an increasingly litigious environment in which accountability is more and more subject to judicial determination. Virtually every element of organized society is plagued by this nemesis: from banks to Boy Scouts, from architects to ice rinks. The range of possibility for suits has gone beyond imagination, and certainly beyond common sense. For many organizations and individuals in the United States, insurance is either no longer available or unaffordable. In such an environment, the physician stands a prime object of attention. One can hardly wonder at it. As a result, at present, six of ten physicians in the United States report having been sued during their careers, four of ten in the past five years. Over 70 percent expect to be sued at least once. In a recent year, 40 percent of all claims closed resulted in payments averaging $81,000 each. Today, the average physician pays $17,000 a year for liability coverage. A rare few in high risk specialties pay over $200,000 a year. Overall, 11 percent of an American physician's professional expenses now go for insurance fees. Defense costs alone are staggering. An adverse judgment can be a financial death sentence. A number of physicians in fields such as obstetrics and gynecology are leaving their specialties or limiting their practices to avoid liability costs and liability exposure.

As you may know, efforts are being made by a variety of medical groups to alter the tort system in the United States to control this problem. Some of these efforts are wise, some are not so wise, and some are foolish. It is also pointed out, quite rightly, that medicine is as much art as science and that cure cannot be considered an assured result of treatment — that people's expectations are far too high and they should have a more realistic understanding of what the physician can and cannot do. And there are those who hold attorneys and insurance companies responsible for the liability problems facing medicine and seek ways to control both. These are certainly understandable reactions to a serious challenge. But they cannot be allowed to hide the fact that the area in which the physician can have a very significant impact, and the most direct ameliorating influence, is in the more effective control of medical practice. It is simplistic to say, of course, that the solution to the medical malpractice problem is to end malpractice. Legally, that could only be achieved by ending medical practice itself. Human error is inevitable, accident is in-

evitable: the poor result will occur despite the finest efforts of the brightest and best. And the law will see to it that redress is made. Malpractice, as a legal phenomenon, springs only in small part from the actions of unfit physicians, after all. The most skilled physicians and those who undertake the most difficult tasks with all the tools modern medicine can bring to bear are sued and will continue to be sued. That, too, is inevitable and is part of the brittle world of accountability in which physicians now live. Granting that, however, does not lift the professional burden physicians share in dealing with what must not be assumed to be inevitable — incompetent and unfit practice.

All of this is very uncomfortable, but has served a good purpose, I believe, in firming medicine's resolve. Physicians have had no choice but to turn serious and concerned attention to their own ranks in response to the dynamic pressures facing them. As Dr. Samuel Johnson said so well, "When a man knows he is to be hanged . . . it concentrates his mind wonderfully." Heaven knows, medicine is concentrating today! And a major focus of that concentration is the problem physician. A sobering and healthy shock of recognition is running through medicine, to some extent reminiscent of the cartoon character Pogo's revelation, "we have met the enemy and they is us." In this particular case, and at the risk of excommunication from the church of the venerable Pogo, I might suggest that phrase be modified to, "we have met the enemy, and they is some of us." And I do not mean only those who are themselves unqualified, unfit, and impaired. Included are those who, saying, "there but for the grace of God go I," shield the problem physician to one degree or-another, or who, saying, "I daren't risk being involved," refuse to participate in meaningful peer review activity or to cooperate with improving the efficiency of medical discipline. This ugly side of medicine is well-known to physicians: it is no secret. Like an image viewed through a glass darkly, however, it has in the past too often been ill-defined. One does not willingly recognize an unpleasant image as part of oneself. The prospect is disturbing — self-discovery usually is — but must be faced, for another price of professionalism is responsibility to the public, to the profession, and, finally, to oneself.

Original Licensure: Prevention

The responsiblity of medical licensing and disciplinary boards, as the statutory authority through which the state and the profession can most effectively act, is to protect the public from unqualified, unfit, and impaired physicians. And the process must begin at the moment of original licensure. Surely, it is easier and far cheaper

to deny initial licensure to an unqualified or unfit physician than to revoke or limit a license once given. To short the licensing process will result in increased disciplinary problems and costs. Such an approach, that emphasizes the remedy of discipline over the prevention of sound licensing, is patently illogical. Because, as experience has shown, there are those applicants who will present false credentials, effective verification procedures are clearly essential. Because, as some have suggested, there may well be medical school faculties and residency program directors who will be less than candid in pointing out an applicant's more serious problems to a board, reliable evaluations at all levels of the educational process are required; and the boards, in an appropriate way, should have access to the results. In fact, the Federation advocates a limited, educational license for residency training, in part to stimulate a more effective review and evaluation system prior to the application for full licensure. (In this context, I should mention that in the United States there is a perception that once admitted to a medical school, one must go to some lengths not to graduate: failure rates are remarkably low. Some observers have suggested that we in the United States appear to be blessed with medical school admissions committees of singular skill and sensitivity. And if one is to judge by reports concerning the letters of some deans and residency directors about graduates, incompetence and impairment might almost be the products of licensed medical practice, as they seem very seldom apparent during training.) Indications of trouble may be available in the public record as well: court records, law enforcement files, etc. Candidates should also be reviewed against the records of other states; mobility can be an effective smokescreen. And the value of the personal interview in triggering recognition of potential problems should not be ignored.

In this same vein, the Federation is urging that medical boards require a written clinical examination, such as the new SPEX, for the physician who seeks licensure by endorsement of another state's license and who is eight to ten years away from any other testing approved by the medical board to which the physician is making application. Some states now have this policy and the Federation hopes all will adopt it to assist in determining that physicians who leave their established practice and peer review environments to enter new jurisdictions have maintained their qualifications over time.

Altogether, boards should do all in their power to license only those who are able and willing to practice medicine with reasonable skill and safety. Prevention is preferable to remedy.

In the United States in recent years, the development of a strong state licensing examination in the FLEX, the growth of sophisticated information systems such as the Federation's Physician Disciplinary Data Bank, the newly developed Special Purpose Examination, improved medical practice acts in many jurisdictions, better communication among boards, and more have marked a steady progress in what was once a perfunctory licensing process. But unfortunately this is not the best of all possible worlds, and licensure, by examination or endorsement, is not always what we would have it be, while some physicians, once licensed, fail to maintain the professionalism they first bring to practice, a problem nothing short of clairvoyance may ever solve.

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Concentrating on the Problem Physician: Perspectives in Medical Discipline — Part II

DALE G BREADEN

DISCIPLINE: REMEDY

As a Federation leader said some years ago, a state medical board's main objectives are "fitness determination and the maintenance of discipline." They are, in fact, the two elements that express the equation of responsibility for all the boards. And when the process of licensure is less than it should be, when the licensee proves less than he or she ought to be, the disciplinary element is essential in protecting the public from the consequences.

So we face the need for remedies, and successful outcomes will require early identification of problem physicians. To passively await disaster is to actively invite disaster, and every resource available to a board should be used to identify the possibly unqualified or unfit physician. Anything less is too little too late. And I should note that legislative bodies or government authorities that fail to provide boards the tools they need to do this must bear responsibility for the results of that failure. But while the task before boards must be pursued diligently, it should not interfere needlessly with the practice of medicine by the overwhelming majority of fine physicians.

The need to identify possibly unfit, unqualified, or impaired physicians is fundamental to the work of the boards, and the task cannot be done in an information

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Delivered in Adelaide, Australia, as the keynote address for a two day seminar on the Identification and Management of Professional Incompetence — Assistance for the Distressed Doctor. Sponsored by the Australian Medical Council (AMC), the Medical Board of South Australia, and the South Australian Postgraduate Medical Association, the seminar was held on June 18 and 19, 1988, at the Medical School of the University of Adelaide. Mr. Breaden, associate executive vice president of the Federation of State Medical Boards, was in Australia for three weeks as a guest of the AMC visiting state medical boards and various medical organizations and attending the AMC's Annual General Meeting.

Though the word physician has a more restricted meaning in Australia (and several other English speaking countries) than in the United States, it is used here in its broad sense to include all medical practitioners. — DGB

Mr. Breaden's Australian presentation has been divided into two parts for publication in the BULLETIN. Part I, in the February 1988 number, described the current status of medical licensure in the United States. In this somewhat longer second part, Mr. Breaden provides a detailed discussion of the regulation of medical practice in this country. — Ed.

vacuum. The so-called conspiracy of silence, which was no myth among physicians, is dying away in the face of today's realities. There is really no choice because the unfit practitioner must be weeded out to protect the profession as well as the public.

Markers and Indicators/ Reregistration

Much of the information required for early identification of possible problem physicians is or should be available. It is not necessary to create mass relicensure testing systems, as some have suggested, nor is it necessary to put every physician through elaborate, time consuming, and costly evaluation processes every several years. It is necessary, however, to secure and use the information that is generated every day reflecting physician performance. That information can provide the markers and indicators a board needs to identify the possible problem physician; and I again stress the word possible, because identification is only the beginning of a process of review conducted in the context of law.

After several years of work, a Federation committee developed the concept of markers and indicators several years ago and recommended a license reregistration system be used to implement an efficient physician assessment program based on that concept, an early detection process coordinated with the license reregistration system.

A policy statement adopted by the Federation also calls for the establishment of assessment programs keyed to reregistration in all jurisdictions.

Fortunately, many medical boards are adopting more effective license reregistration rules that require the filing of forms on which licensees report any sanctions taken against them during the reregistration period, usually one or two years. The number of states in which physicians could simply mail a check to reregister their licenses is decreasing noticeably, as it should be. The Federation expects reregistration procedures to become more significant over the next few years. At the same time, we firmly reject any suggestion that physicians should be required to pass a formal reregistration or relicensure examination to continue practice.

What I should like to do is suggest some of the potential that exists now for creating assessment programs, programs springing from markers and indicators of performance and fitness that should draw a board's attention to the potential problems of specific licensees.

Here, we are concerned with diverse information available from various official and professional sources. The peer review processes of hospitals and other health care entities, and the sanctions they may lead to, such as privi-

In the wine country of South Australia. **From left, Mr. Breaden, Dr. Bernard J. Amos, president, Medical Board of New South Wales, and Mrs. Breaden.**

lege restrictions or denials, are essential to physician self-regulation. Done in keeping with appropriate due process rules, peer review can provide the most valuable indication of performance available to a licensing board. Today, in the United States, peer review activity is gaining more effective, though far from perfect, protection at state and federal levels. Recent federal legislation (the Health Care Quality Improvement Act of 1986) that offers limited immunity for peer review conducted in accord with due process reflects the growing national awareness that there can be no substitute for sound peer review. Physicians who once may have hesitated in cooperating with the process or in using it effectively have less and less excuse to stand back from it. Clearly, peer review sanctions related to clinical ability must be available to boards. And this should include information from our government's own contracted peer review organizations (PROs), which oversee the Medicare/Medicaid systems.

When a physician is licensed or otherwise authorized to practice in more than one jurisdiction, adverse actions taken by any of those jurisdictions must be made known to the others as soon as possible. Such actions are primary red flags and no board can permit itself to delay responding to them. The Federation's Physician Disciplinary Data Bank is a direct expression of the importance of such information to all boards.

Liability judgments, settle-

ments, and awards may be significant markers, particularly when they form a pattern of performance-related problems. Taken alone, as I have noted, they can be meaningless, reflections of inevitable human error or levels of risk and not of qualification or fitness. They may also spring from personal issues unrelated to care, or be the result of simple opportunism. Their relationship to ability and skill is tenuous. But they cannot be ignored. They must be known to the board and their meaning must be determined by the board.

These three sources of information — peer review, board action, and liability — are of primary importance. They are the elements on which the new federal law, to which I have referred, centers its attention. Other markers and indicators, other potential red flags, are available, however, and should be used.

Conviction on or entry of a nolo contendere plea to felony charges, adverse actions taken by professional societies, and physical or mental illnesses potentially affecting the safe practice of medicine require close attention. All these markers and indicators should be gathered systematically, and two complementary approaches can provide such a system, each supporting and enhancing the other.

A. *Self Reporting*

First is license reregistration itself, a moment in time when each licensee can be required to report adverse information, if any, to the board for its review. Reregistration fees, by the way, range from zero per year to $200 per year in the United States — an incredible disparity. Because an effective assessment reregistration system requires adequate funding, it would appear some boards will need to reexamine their reregistration fee structure.

Self-reporting by licensees, on a well-designed form personally signed by the licensee, is the first half of the data-gathering process. An annual reregistration pattern might well be used to develop a staggered biennial data review system, allowing staff to concentrate on half the enrolled licensees per year. Clearly, whatever reregistration time frame is adopted, it must allow for adequate but reasonably prompt review in accord with guidelines and protocols designed to process forms efficiently while noting evident red flags. Self-reporting forms will only be valuable as tools for identifying possible problem physicians if they are effectively screened.

A number of boards in the United States are now requiring the self-reporting of some or all of the information called for in the markers and indicators approach.

Hospital peer review actions must be self-reported in thirty-three jurisdictions. Adverse actions by other licensing authori-

ties must be self-reported in thirty-eight jurisdictions. Self-reporting of liability actions is required in twenty-seven jurisdictions. Drug Enforcement Agency (DEA) restrictions must be reported in twenty-eight jurisdictions, professional society actions in twenty-eight, personal drug or alcohol abuse in twenty-eight, physical or mental illness in twenty-one, felony convictions or nolo contendere pleas in thirty-five. In each of these jurisdictions, the groundwork is already laid for establishing a sound reregistration assessment program. Some are now implementing such an effort. Unfortunately, twenty-five jurisdictions ask no questions related to performance or fitness. But obviously, the days of "send in your current address and $10" are rapidly disappearing.

By the way, I should note that of the Federation's sixty-five member boards, thirty-two report they have continuing education requirements that must be completed for license reregistration. Like data on hospital staff membership, certification, professional society membership, and areas of professional activity, such information provides a part of a board's overall profile of a licensee's professional environment, a profile that sound reregistration procedures should keep current and in which sudden changes should be thoughtfully reviewed.

B. *Mandatory Reporting*

The information provided by assessment reregistration, because it is self-reported, requires the reinforcement of mandatory reporting laws. Hospitals, liability carriers, professional societies, the courts, all health profession licensees, and others with pertinent information should be required to report sanctions, adverse findings, or possible violations of the medical practice act to the board.

Many states have enacted legislation requiring reports to the boards by certain persons, institutions, and organizations. Although these compulsory reporting laws vary from state to state, they usually pertain to health care facilities, liability insurance carriers, and individual licensees. They may also require reports from courts, law enforcement agencies, and medical societies. With the exception of individual licensees required to report apparent violations by other licensees, reporting laws usually involve informing the medical boards of specific formal disciplinary or legal actions. However, when a physician withdraws from a medical staff while under review for disciplinary reasons, that fact may also have to be reported, as it should be.

The Federation has actively encouraged these laws. Its *Guide to the Essentials of a Modern Medical Practice Act* states this position clearly. This is not to deny the value of complaints received from the public. Such

complaints are vital and can lead to significant action. Often, however, they involve issues that do not reflect upon a licensee's fitness for practice. To improve and encourage this source of information, the Federation has developed and distributed a *Model for the Preparation of a Guidebook on Medical Discipline*. The boards can use this publication, among other things, to assist the public in understanding the role and disciplinary function of the state medical boards, increasing the quality of public reporting and reducing meaningless complaints. But we have found medical boards cannot function as effectively as they must without the information provided through enforceable compulsory reporting laws.

Today, hospitals are required to report peer review actions in fifty-one jurisdictions. Liability data is reported in thirty-nine jurisdictions, though the nature of the information reported varies significantly from one jurisdiction to another. Courts report to the boards in twenty-two jurisdictions and other law enforcement agencies in twelve. Professional societies must report sanctions in thirty jurisdictions. Under what used to be called the snitch law, but which, in fact, simply requires the fulfillment of a professional duty for the benefit of the public and the profession, licensees are required to report errant colleagues in thirty-six jurisdictions. State agencies are required to report in seventeen jurisdictions. Nine jurisdictions require physicians treating other physicians to report under certain conditions. PROs are required to report in eight jurisdictions. However, few jurisdictions say their mandatory reporting laws carry significant penalties for not reporting. Certainly, the new federal legislation adds teeth to the hospital and liability reporting requirement by withholding immunity protection in the former case and by imposing a heavy monetary penalty in the latter; but the states must also address the issue.

Nonetheless, the trend is clear and encouraging. And, hopefully, the Federation has played a part in stimulating the mandatory reporting concept through its *Guide to the Essentials of a Modern Medical Practice Act*, its public statements, its *Model for the Preparation of a Guidebook on Medical Discipline*, and, now, its reregistration assessment program.

Immunity/Due Process

Essential to mandatory reporting is protection for those who report. When acting in good faith, they must be assured immunity at both state and federal levels. Similar protection must extend to medical board members, staffs, committees, and to all those engaged or assisting in legitimate professional peer review. Equally

important, however, is the legal protection of the accused physician, who must be assured of due process and must be shielded from harrassment.

Using Available Data

Today, the fundamental tools for implementing an effective assessment program exist in many if not most jurisdictions in the United States. Certainly, the informational resources are available almost everywhere. It must be said, however, that the states must provide the funds, through a reasonable fee structure dedicated to board support, and staff to allow the system to work. Collecting data is only a beginning. Forms must be reviewed, markers isolated, data coordinated, and possible problem physicians identified and dealt with promptly and fairly. It is an active effort that seeks out the unqualified and unfit. It requires active support from legislators, the profession, and the public.

In a very real sense, physicians are being tested every day. In the context of their practices, the professional and legal environments in which they function as physicians and as human beings, they are being continually evaluated. The results of that testing, that evaluation, can and should be available to the boards responsible for the protection of the public interest. And the boards should be equipped to handle those results. We believe a coherent reregistration assessment program, combined with meaningful mandatory reporting, could achieve the purpose.

Disciplinary Action

Once identified, physicians who present concerns to medical boards can be more precisely evaluated through appropriate means: informal interviews, written inquiries, physical and/or mental examinations, cognitive and/or skills examinations, investigations, etc. If boards are properly funded, if a markers and indicators system is implemented, and if mandatory reporting is universally adopted, effort will be concentrated where it belongs: on those who have demonstrated inadequate professional ability or fitness.

If the boards have available to them, as well, a wide range of disciplinary actions — revocation, suspension, probation, license restriction, chastisement, fines, etc. — they can also address each violation of the medical statute in the most effective way. Most commonly, this will not result in a physician's permanent loss of license, but in corrective or educational action that will change behavior appropriately and protect the public while salvaging a physician's medical skills.

I should note, parenthetically, that in the United States — and I wonder if the same is true here — the media and certain self-appointed consumer advocacy

groups tend to think the only action a board should take, the only action with any meaning, is license revocation. Off with their heads! This is a lamentable misunderstanding of the purpose of boards. It is like measuring the criminal justice system by how many people have been hanged. In a very real sense, revocation is a failure for all concerned: physicians, board, and public. Everyone loses when a physician cannot be salvaged or rehabilitated. It happens, it must happen, to protect the public and to uphold the integrity of the profession. But the flexibility available to a board that has a wide range of penalties to draw on at least offers the possibility of adding another constructive dimension to medical discipline.

Competence

Now, I trust you have noticed I am not concerned with elaborate systems for evaluating the competence of all physicians. First, I seriously doubt that is feasible. Competence, as simple as the word seems, is an elegantly complex concept that defies our limited assessment abilities. Second, it is not economically justified. The cost-benefit ratio of the effort, flawed in any case, would be terribly skewed. Third, I do not believe it is necessary in order to achieve the purpose of protecting the public. Years ago, someone asked the notorious American bank robber, the dapper Willie Sutton, why he robbed banks. Willie's reply was immediate: "Because," he said, "that's where the money is." And so it is with this issue. If we are striving to identify the problem physician, we have to look where he or she is to be found, not at the whole universe of physicians. Look for the signs of incompetence, not competence.

Unfortunately, in New York State today there is a movement, backed by the governor and certain state health officials, to establish a system for mass evaluation of licensed physicians. I shall not go into all the details of the proposed plan, but I shall tell you our Federation is firmly opposed to what we believe would be, in effect, a wasteful and pointless exercise. Cost and other serious problems, including potential discrimination in the diverse and unrelated methods of proposed evaluation, may well cause the effort to degenerate into a mass cognitive testing system keyed to the lowest common denominator. Worse, however, if it goes forward, it will deceive the people of New York State, for a time, into believing they are actually protected from incompetence and will turn attention from the effective methods the state could be using to identify those who are incompetent. That would be a tragic irony. The New York proposals would build a medical Maginot Line, an elaborate defensive system facing the wrong way

and creating a false sense of security.

Impaired Physicians

Let me turn for a moment to the problem of impaired physicians, particularly those addicted to alcohol and drugs. They represent a dramatic threat to patients and a tragic potential loss to medicine. Clearly, boards should have the authority to require chemical dependency examinations and other appropriate assessments of physicians suspected of impairment. With positive findings, and after proper hearings, boards should take those actions that best protect the public. As required, the license can be revoked or suspended, the physician put on monitored probation or otherwise appropriately restricted in practice. And the physician should also be directed to submit to board approved care, counseling, and treatment. The impaired physician, in a number of cases, has been shown to be a salvageable resource, after all.

In the United States, impaired physician programs have been developed by medical boards, medical societies, and some private entities. Some have achieved commendable results. One frequently cited and emulated to one degree or another is the Georgia Impaired Physicians Program operated by Dr. Douglas Talbott. It is guided by four fundamental principles: identification, intervention, assessment/treatment, and re-entry.

Talbott believes up to 15 percent of physicians, at some point in their careers, will become impaired, largely by alcohol and drugs. He also maintains that indications of that impairment will appear last in the practice setting, making early identification more difficult for colleagues. Once identified, the physician must be confronted, often a grim experience for the intervenor, and convinced to admit the impairment and the need for help. Motivation is provided by the knowledge that a report to the medical board will be made, that denial will not work any longer. At that stage, the physician is required to sign a contract of intent to accept the program. Then an intensive assessment and treatment effort begins. The initial part of that process can last up to four months. Treatment, in company with other physicians — to overcome the Me-Deity syndrome — leads to stays in special recovery houses and to outpatient programs. As part of the self-discovery process, the physicians are trained to act as counselors to other impaired physicians in a system called mirror-image therapy. They also appear before third and fourth year medical students in it couldn't happen to me sessions. Needless to say, from the outset, family and other support systems are heavily involved. Finally, when the time is right, practice reentry is

planned and a twenty-month aftercare program is designed. Again, the physician must agree to the program in a contract. Monitoring, of course, is used extensively as the physician moves into practice and relapses are dealt with swiftly and supportively. Tough love is the term Talbott uses. Other successful programs follow similar methods.

Long term relapse figures are difficult to verify. They may look encouraging, but addiction, as you know far better than I, is a day-to-day disease, and figures are never final. The benefits of programs like Georgia's, however, are proving worthwhile. But it must be remembered that the motivation provided by the power of the medical board, always in the background and always available to act, can be one of the most valuable tools any impaired program possesses.

But what of the unidentified and unreported impaired physician? He or she should be encouraged to seek treatment. To this end, we believe the board should be authorized, at its discretion, to establish rules and regulations for the review and approval of medically directed, nonprofit, voluntary treatment programs for impaired physicians that meet standards set by the board. Those conducting a board approved treatment program should be exempt from the mandatory reporting requirement relating to an impaired physician who is participating satisfactorily in the program, or their report should be held in confidence and without action by the board unless or until the impaired physician ceases to participate satisfactorily in the program. The standards set by the board should require that any impaired physician whose participation in an approved treatment program is unsatisfactory should be reported to the board as soon as that determination is made. Of course, participation in an approved treatment program should not protect an impaired physician from board action resulting from a report of his or her impairment from another source. The board should be the final judge of a treatment program's acceptability.

The Physician Disciplinary Data Bank

From what has already been said, it should be clear that the computerized Physician Disciplinary Data Bank (DDB) is an essential function of the Federation's role in relation to effective medical discipline, a role deeply rooted in the Federation's history and experience. Since 1915, the Federation has collected and disseminated information on formal disciplinary actions taken by its member medical boards against licensed physicians and applicants for licensure. For many years, however, reporting by the boards was inconsistent and uneven. In the early 1970s, the

monthly Disciplinary Action Report was created, improving communication amongst the various state boards, and, throughout the decade, the level and quality of reporting by the medical boards steadily improved. More began to use the Disciplinary Action Report as a resource to identify their licensees disciplined in other jurisdictions. Meanwhile, a formal recording system was developed by the Federation, establishing a permanent card file of disciplinary actions as a continuing reference source for all medical boards.

With the advent of cost-effective small computers offering large capacity and high speed, the Federation began planning the computerization of its rapidly growing disciplinary data base in the early 1980s. The process was begun using microcomputers. In late 1984, a state-of-the-art computer was installed, bringing what by then was called the Physician Disciplinary Data Bank to a high level of sophistication. By that time, with rare exception, all medical boards were reporting their formal disciplinary actions to the Federation and using the DDB to review applicants for licensure. Today, member medical boards have become active contributors to and users of the DDB, and its effectiveness is being clearly demonstrated as the Federation responds to requests for disciplinary data from medical boards and other agencies.

The DDB collects and stores disciplinary actions taken against physicians resulting from formal charges. The information is reviewed and categorized before being distributed monthly to all United States and territorial medical boards, to Canadian provincial licensing authorities, to the American Medical Association for use in its Physician Masterfile Data Base, to the American Osteopathic Association, the DEA's domestic regional offices, the Department of Defense, the Department of Health and Human Services, and others. The report contains information vital to licensing and disciplinary boards in making responsible licensing decisions. It also permits the review of the disciplinary status of a state's licensees in other jurisdictions. The DDB has been responsible for dramatically reducing the movement of problem physicians from one jurisdiction to another undetected — a major accomplishment.

Clearly, actions ultimately reported to the Federation do not begin to reflect the full extent of medical board effort. As you are very much aware, the disciplinary impact of medical boards cannot be measured by the number of formal disciplinary actions they take. In the United States, most boards will deal informally with five to ten licensees for every formal action. More often than not, these contacts are sufficient to significantly affect the behavior

and/or performance of the licensees involved and to prevent the development of more serious problems calling for formal action. Beyond this, the process of identifying those physicians actually requiring formal or informal attention by a medical board often demands the careful review and closure of hundreds of cases or complaints, a difficult and time-consuming task.

The Federation's DDB has rapidly become a basic working tool for the physician licensing and disciplinary boards of the country. No formal disciplinary action can be considered complete until reported to the DDB; no application for licensure can be considered fully evaluated until screened through the DDB; and no disciplinary system can be considered effective until it includes regular review of the monthly DDB report. All of this, however, is possible only because the boards themselves have cooperated to make the DDB a reality.

The Federation's DDB has also been used over the past two and a half years to screen all physicians in the military services, the National Guard, the military reserves, the Veterans Administration (VA), and the Public Health Service. This task was facilitated by the use of nine-track tapes prepared according to Federation direction. The DDB is used as a recruitment or hiring screen by those same organizations. At the same time, the armed forces, the Department of Health and Human Services, the Educational Commission for Foreign Medical Graduates, and the United States Postal Service report disciplinary actions and other sanctions to the DDB. The VA is also authorized to report sanctions to the Federation. Several hundred hospitals and many national and regional health maintenance organizations and preferred provider organizations use the DDB as a screen for hiring or privileging, as well. These wide ranging DDB services, available to those agencies or bodies needing such information in fulfillment of their lawful functions, are conducted under formal contract for an appropriate fee. Full legal responsibility for use of the data is specifically assumed by the entities contracting to receive them.

What the DDB provides is a triggering mechanism, an alert system, that indicates an adverse report, based on legally accessible information, has been made to the Federation concerning a particular physician. While the Federation has board orders and other documentation supporting the report, that material is not provided to the inquiring user. The DDB describes the nature and source of the report and specifically directs the user to the original reporting jurisdiction for verification and detail. No user is to make a judgment based on a DDB report alone. To do so would

"G'day!" Mrs. Dale Breaden greets a newfound friend.

be irresponsible and a violation of the DDB contract. For this and other reasons, DDB reports are to be held in confidence by the users.

The Federation is going forward now with further development of the DDB. As an example, a program is now being implemented to permit state medical boards to receive an initial response (yes, no, or possible) to a disciplinary inquiry through a direct on-line computer system. That system is fully secure and does not involve a direct connection to the DDB itself.

Such a system is a logical expression of the Federation's determination to see that the disciplinary information program begun so long ago continues to improve in efficiency and responsiveness. That program represents a unique contribution to the protection of the American people and to the integrity of the medical profession.

Federal Legislation: Title IV, PL 99-660

It should be evident from all of this that thoughtful federal legislation promising to assist the state boards in their disciplinary tasks is welcome. Two years ago, when the Health Care Quality Improvement Act of 1986 was introduced in the Congress of the United States, the Federation testified in favor of the legislation and worked as closely as possible with congressional staff as the bill went forward. The Federation understood the legislation was not ideal, and that, badly handled, it could be as much hindrance as help. But the bill addressed vital

issues, and, fortunately, reflected many positions advocated by the Federation.

The legislation finally passed as Title IV of Public Law 99-660. While still not ideal, it is the law. Amongst other things, Title IV extends immunity protection for those participating in professional peer review activity, if that activity is conducted in accord with specified due process procedures, and requires the reporting of malpractice and hospital privileging data to state medical boards. It also requires the Secretary of the Department of Health and Human Services (DHHS) to establish or designate a national repository of adverse malpractice, disciplinary, and hospital privileging data to which professonal liability insurers, state medical boards, and health care institutions must report. In turn, health care institutions wishing to benefit from the protections of Title IV are to screen the members of their medical staffs through the national data base when privileges are requested or renewed. Screening of each staff member is to be done at least once every two years. Clearly, the use of the data in the repository by health care institutions will require great care. This will be particularly true in the case of malpractice data, the value of which is open to serious question.

In supporting the legislation, the Federation strongly advocated immunity protection for professional peer review and mandatory reporting of malpractice and hospital privileging information to state medical boards. It urged, however, that implementation of a national data repository under the Secretary of DHHS be postponed until the other elements of the law had had a chance to affect the system. Having extensive experience in the area of disciplinary data collection and national screening programs, the Federation believed more detailed study of the repository envisioned by the statute was clearly needed. Such was not the will of Congress, however. The repository is to be established and functional as soon as possible (and when funded) under a contract to be awarded by the Health Resources and Services Administration. That being the case, the Federation and the AMA have approved a partnership between them for the sole purpose of presenting a bid for joint operation of the data repository called for in Title IV. Under the arrangement, the Federation would operate and fully control the disciplinary component of the repository. The Federation's DDB would continue to function as it does now. The AMA would develop and operate the malpractice and hospital privileging components of the repository.

Conclusion

Finally — and I know how pleased you are to hear that word

— finally, after all of this has been said, I must emphasize again that it is only a small group of licensees we are concerned with here. The overwhelming majority of physicians practice with ability, skill, and integrity, a point no one must ever forget or doubt. And they want their profession rid of the unqualified and the unfit. They want the community of medicine in good order because it is theirs, they live in it, and they are justly proud of it. It is, I fervently believe, a city on a hill.

To your eyes and mine, because of our charge, the ugly side of medicine may seem more vivid than it does to many, but it should not distort our vision or make cynics of us. As the product of the natural frailty afflicting any worthwhile human endeavor, it adds dimension and perspective to our appreciation of medicine's real burden, the fundamental concern of medicine that remains what it has always been: to struggle within the limits of the human mind and heart against death, disease, disability, pain, and suffering — to do so with compassion and understanding while doing no harm. And it is that struggle that defines medicine and the physician and creates the city on the hill.

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LICENSE REREGISTRATION

TABLE 1 LICENSE REREGISTRATION - FREQUENCY, FEES, LATE PENALTIES
Frequency of required license reregistration, reregistration fees, and late fees.

	Reregistration Frequency	Reregis. Fee	+ Late Fee
AL	1 yr	$50	
AK	2 yrs	$400	$30
AZ	1 yr	$150	$250
AR	1 yr	$25	$1
CA	2 yrs	$255	first 90 days: $25.50 after 90 days: $127.50
CO	2 yrs	$84	varies
CT	1 yr	$160	
DE	2 yrs	$110	
DC	2 yrs	$120	$10
FL	2 yrs	$250	$50 (reactivation fee)
GA	2 yrs	$75	$75 $300 reinstatement
GM	2 yrs	$60	
HI	2 yrs	$200	$50
ID	1 yr	$90	$100 (for reinstatement)
IL	3 yrs	$300 IL resident $600 non-resident	$100 (for reinstatement)
IN	2 yrs	$50	$50
IA	2 yrs	$150	$25 minimum $100 maximum
KS	1 yr	$150	$50
KY	1 yr	$65	$25 first 30 days $100 after 30 days
LA	1 yr	$100	$100 (varies after 1 yr)
ME	2 yrs	$100	$25
MD	2 yrs	$90	$25 (for reinstatement)
MA	2 yrs on physician's birthday	$150	
MI	3 yrs	$120	$20
MN	1 yr	$115	$55
MS	1 yr	$100	$25 + $5 per mo
MO	1 yr	$30	$55
MT	1 yr	$35	
NE	2 yrs	$100	$25
NV	2 yrs	$300	$300
NH	1 yr	$50	
NJ	2 yrs	$160	$25
NM	3 yrs	$60	(to be established)
NY	3 yrs	$220	
NC	2 yrs	$70	$20
ND	1 yr	$60	$180 after 30 days
OH	2 yrs	$100	$25
OK	1 yr	$100	
OR	1 yr	$105	$100 + reregis fees
PA	2 yrs	$25	$5 per month
PR	No Information Provided		
RI	1 yr	$50	$50
SC	1 yr	$90	$10 per month
SD	1 yr	$100	
TN	1 yr	$40	$100
TX	1 yr	$202	$100 after 90 days $200 after 1 yr
UT	2 yrs	$75 (+ $50 controlled sub lic)	$10 w/in 30 days $50 after 31 days to 2 yrs
VT	2 yrs	$100	
VA	2 yrs	$120	$25
VI	No Information Provided		
WA	1 yr	$60	$10
WV	2 yrs (odd numbered yrs)	active: $200 inactive: $50	
WI	2 yrs	$82	$5 one month $25 after 1 month
WY	1 yr	$40	

Totals: *1 yr = 23*

Extracted from the 1989 - 1990 Federation Exchange, Section 1.
Fort Worth, Texas: Federation of State Medical Boards of the United States, Inc.

TABLE 2 LICENSE REREGISTRATION - CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS
Board requirements for accumulation of continuing medical education (CME) credits prior to each license reregistration.

	No	Yes	Amount Required
AL	X		
AK		X	17 hrs Category I per yr
AZ		X	20 hrs per yr in any category
AR	X		
CA		X	50 hrs Category I per 2 yrs
CO	X		
CT	X		
DE		X	40 hrs Category I per 2 yrs
DC	X		
FL		X	40 hrs Category I per 2 yrs, 5 hrs of which must be in risk mgment.
GA	X		
GM		X	Not listed
HI		X	50 hrs per yr, 20 hrs of which must be Category I
ID	X		
IL	X		Not listed
IN	X		
IA		X	40 hrs Category I per 2 yrs
KS		X	150 hrs per 3 yrs, 60 hrs of which must be Category I
KY	X		
LA	X		
ME		X	100 hrs per 2 yrs, 40 of which must be Category I
MD		X	40 hrs Category I and 60 hrs Category II per 2 yrs
MA		X	100 hrs per 2 yrs, at least 40 hrs Category I, 10 hrs risk mgmnt, 2 hrs on board regs
MI		X	150 hrs per 3 yrs
MN		X	75 hrs per 3 yrs (at least 45 hrs Category I, no more than 30 any other single Category)
MS	X		
MO		X	75 hrs Category I per 3 yrs
MT	X		
NE	X		
NV		X	20 hrs per yr
NH		X	150 hrs per 3 yrs
NJ	X		
NM		X	75 hrs Category I per 3 yrs
NY	X		
NC	X		
ND	X		
OH		X	100 hrs per 2 yrs, 40 of which must be Category I
OK	X		
OR	X		
PA	X		
PR	No Information Provided		
RI		X	60 hrs per 3 yrs
SC	X		
SD	X		
TN	X		
TX	X		
UT	X		
VT	X		
VA	X		
VI	No Information Provided		
WA		X	150 hrs Category I per 1 yrs
WV	X		
WI		X	30 hrs Category I per 2 yrs
WY	X		
Totals:	*30*	*22*	

TABLE 3 LICENSE REREGISTRATION - INFORMATION REQUIREMENTS
Information that must be reported by licensee to board each time license is reregistered.

	OLB	HSP	PS	DAA	DEA	PMI	LSJ	FC	OTHER or COMMENTS:
AL	X	X	X	X	X	X	X	X	
AK	X	X	X	X		X	X	X	Affidavit of CME
AZ	X	X		X	X	X	X	X	
AR	X	X	X				X	X	
CA									Signed statement of having met CME requirement
CO	X	X		X	X	X	X	X	Malpractice insurance items
CT	X							X	
DE	X	X	X				X	X	
DC	X							X	
FL									Demonstration of financial responsibility and proof of required CME credits
GA	X			X	X		X	X	License demographic information
GM	X	X	X					X	
HI	X								
ID									
IL									
IN	X				X			X	
IA									
KS	X	X		X	X	X	X	X	
KY	X	X	X	X	X	X	X	X	
LA	X	X	X	X	X	X	X	X	
ME	X	X	X	X	X	X	X	X	
MD	X	X	X	X	X	X	X	X	May voluntarily choose to be identified as a specialist
MA	X	X	X	X	X	X	X	X	Specialty(ies) pract; specialty board certif/recertif; proof of required CME credits
MI									
MN	X	X	X	X	X	X	X	X	

KEY TO SOURCES LISTED:
OLB = Other licensing boards info: disciplinary actions/sanctions taken, voluntary license surrenders; HSP = Hospitals info: disciplinary actions/sanctions taken, voluntary resignations from staff; PS = Professional societies info: disciplinary actions/sanctions taken, membership withdrawals DAA = Personal drug/alcohol abuse/addictions; DEA = Loss or restriction of Drug Enforcement Administration registration; PMI = Physical/mental illness potentially affecting safe practice; LSJ = Liability awards, settlements or judgments against applicant; FC = Conviction of felony charges against applicant or applicant's entry of guilty or nolo contendere pleas to felony charges

	OLB	HSP	PS	DAA	DEA	PMI	LSJ	FC	OTHER or COMMENTS:
MS									
MO	X	X	X	X	X	X	X	X	
MT	X	X	X	X	X		X	X	
NE									
NV	X	X	X	X	X		X	X	
NH	X	X	X	X	X	X	X	X	
NJ	X	X	X				X	X	
NM	X	X	X	X	X	X	X	X	Reregistration forms ask in general if any discipline has been taken by any entity
NY									
NC	X	X	X	X	X	X	X	X	
ND	X	X	X	X				X	
OH	X	X		X	X			X	
OK	X	X	X	X	X	X	X	X	
OR	X	X	X	X	X	X	X	X	
PA	X	X	X	X	X			X	States where license is/was held
PR	No Information Provided								
RI									
SC	X	X	X	X	X	X	X	X	
SD	X	X	X	X	X	X		X	
TN									
TX		X	X				X		
UT	X	X	X	X	X	X		X	
VT	X	X	X	X	X	X	X	X	States where license is/was held
VA	X	X	X	X	X	X	X	X	
VI	No Information Provided								
WA									
WV	X	X	X	X	X	X	X	X	
WI									
WY	X	X	X	X	X	X	X	X	
Yes	*38*	*34*	*30*	*30*	*29*	*24*	*29*	*37*	
No	*14*	*18*	*22*	*22*	*23*	*28*	*23*	*15*	

TABLE 2 REVIEW AND DISCIPLINARY FUNCTION - MANDATORY REPORTING OF VIOLATIONS, WHO MUST REPORT, PENALTY FOR FAILURE TO REPORT – Individuals, agencies or other entities required by law to report to the board possible violations of rules of statute. Civil penalties (fines) for failure to report.*

	AL	CL	CRT	HSP	OHE	LIAB	LMS	LPS	OSA	SLLE	SMS	SPS	PRO	PTP	OP	FA	Civil Penalty Y-N
AL	X			X						X				X			
AK	X	X	X	X	X				X	X				X			
AZ-M	X		X	X	X	X	X	X	X	X	X	X		X			No
AZ-O	X			X	X	X	X	X			X	X		X			
AR	X			X													
CA-M			X	X	X	X	X					X					
CA-O	X	X	X	X	X	X	X		X	X	X						
CO	X	X		X		X											No
CT-M	X			X			X				X						
DE	X	X		X	X		X	X	X		X	X	X	X			
DC					X												
FL-M	X			X	X	X	X	X			X	X	X		X		Yes (HSP only)
FL-O	X	X		X		X	X	X			X	X					
GA				X		X											
GM	X	X	X						X	X							
HI-M	X	X	X	X	X	X	X	X			X	X					Yes
ID	X			X													
IL				X	X	X	X		X	X	X						
IN				X					X								
IA	X	X		X		X											Yes (licensees only)
KS	X	X		X	X	X	X	X	X		X	X					
KY	X		X	X		X	X	X	X		X	X					
LA						X											
ME-M	X	X		X	X	X	X	X	X		X	X	X				
ME-O	Information not yet provided																
MD			X	X	X		X	X	X			X					Yes (HSP only)
MA		X	X	X	X	X	X	X	X	X	X	X			X		Yes (HSP only)
MI-M			X	X	X	X											
MI-O			X	X	X	X											
MN	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
MS				X			X	X			X	X					No
MO	X			X	X	X											
MT	X																

*AL = All licensees; CL = Licensee committing a violation; CRT = Courts; HSP = Hospitals (staff/adminis); OHE = Other health care provider entities (eg, HMOs, IPPs, unaffiliated clinics); LIAB = liability insurance carrier(s); LMS = Local med/osteo societies; LPS = Local professional societies; OSA = Other state agencies; SLLE = State/local law enforcement agencies; SMS = State med/osteo societies; SPS = State professional societies; PRO = Professional review organizations; PTP = Physicians treating physicians for special disorders; OP = Other health care professions; FA = Federal agencies

Extracted from the 1989 - 1990 Federation Exchange, Section 3.
Fort Worth, Texas: Federation of State Medical Boards of the United States, Inc.

	AL	CL	CRT	HSP	OHE	LIAB	LMS	LPS	OSA	ILLE	SMS	SPS	PRO	PTP	OP	PA	Civil Penalty Y-N
NE																	
NV-M	X	X	X	X	X	X	X	X			X	X			X		No
NV-O				X			X										
NH	X	X	X	X	X	X	X	X		X	X	X					
NJ				X		X											
NM-M	X	X		X	X	X											Yes
NM-O																	
NY	X	X	X	X	X	X	X	X			X	X			X		
NC				X		X											No
ND	X	X															
OH	X	X	X	X		X	X	X			X	X		X		X	
OK-M				X	X	X	X	X			X	X	X				
OK-O						X											
OR	X			X		X	X	X			X	X	X	X	X		Yes
PA-M	X	X	X DA's	X					X								No
PA-O	X	X															
PR						X											
RI		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	No
SC				X	X	X											
SD				X													
TN-M					X												
TN-O					X												
TX	X	X	X	X	X	X	X	X			X	X			X		No
UT-M	X	X		X	X		X	X	X		X	X					
UT-O	X	X		X	X		X	X	X		X	X					
VT-M				X													
VA	X		X	X	X	X	X	X		X	X	X		X			
VI																	
WA-M	X		X	X	X	X	X		X	X	X		X			X	
WA-O	X	X				X											
WV-M	X	X	X	X	X	X	X	X	X		X	X	X				
WV-O	X	X		X					X	X	X						
WI				X		X			X								
WY	X	X		X	X	X	X	X			X	X					
Totals:	39	29	22	53	33	40	32	26	20	13	31	26	9	10	9	3	

TABLE 3 REVIEW AND DISCIPLINARY FUNCTION - MANDATORY REPORTING, WHAT HOSPITALS/ LIABILITY CARRIERS MUST REPORT -- Privilege actions based on formal peer review activity that must be reported by hospitals; claims against licensees or payments on their behalf that must be reported by liability carriers (and self-insureds).

	Hospitals					Liability Carriers			
	Priv Rev	Priv Sus	Priv Res	Vol Surr	Vol Restr	All Claims	All Pay	Pay Over $	Self-Ins Rpt
AL	X	X	X	X	X	X	X		X
AK	X	X	X	X	X				
AZ-M	X	X	X	X (if to avoid formal action)	X	X (claims reported by plaintiff attorney)	X		X
AZ-O	X	X	X	X (if to avoid formal action)	X	X	X		
AR	X	X							
CA-M	X	X	X	X	X			X (30,000)	
CA-O	X	X	X	X	X			X (30,000)	
CO	X	X	X	X	X		X		
CT-M	Hosps must rept to Bd any phys deemed unable to practice w/reasonable skill & safety								
DE	X	X	X	X	X	X (Reported thru DE Insurance Commissioner)	X		
DC	No Information Provided								
FL-M	X	X	X	X	X	Only notice of policy cancellation/non-renewal required			
FL-O	X	X							
GA	X	X	X	X	X	X (all claims over $100,000 or if two prior)		X (10,000)	
GM	No Information Provided								
HI-M	X	X	X	X	X		X		X
ID	X	X	X	X	X				
IL	X	X	X	X (if to avoid formal action)	X		X		X
IN	X	X	X	X	X	IN Department of Insurance reports "panel opinions"			
IA	X	X	X	X	X	X			
KS	X	X	X	X	X	X (Reported thru KS Insurance Commissioner)	X		X
KY	X	X	X	X	X	(Reported thru KY Department of Insurance)	X		
LA								X (1,000)	
ME-M	X	X	X	X	X	X	X		
ME-O	Information not yet provided								
MD	X	X	X	X	X		X		X
MA	X	X	X	X	X	X	X		X
MI-M	X	X	X	X	X	X			
MI-O	X	X	X	X	X	X			
MN	X	X	X	X	X		X		X
MS	X	X	X	X	X				

Priv Rev = Privilege revocation; Priv Sus = Privilege suspension; Priv Restr = Privilege restriction; Vol Surr = Voluntary surrender of privileges; Vol Restr = Voluntary restriction of privileges; All Claims = All claims; All Pay = All liability payments made by carrier; Pay Over $ = Dollar amount above which all payments must be reported; Self-Ins Rpt = Self-insureds must also report

	Hospitals					Liability Carriers			
	Priv Rev	Priv Sus	Priv Res	Vol Surr	Vol Restr	All Claims	All Pay	Pay Over $	Self-Ins Rpt
MO	X	X	X	X	X	X			X
MT	No Information Provided								
NE									
NV-M	X	X	X	X	X	X		X (5,000)	X
NV-O									
NH	X	X	X	X	X	X			X
NJ	X	X	X	X	X			X (25,000)	X
NM-M	X	X	X	X	X	X	X		X
NM-O									
NY	X	X	X	X	X	X	X		X
NC	X	X	X	X	X	X	X		
ND									
OH	X	X	X					X	X
OK-M	X	X	X	X	X	X	X	X	
OK-O						X	X		
OR	X	X	X			X	X		X
PA-M	X	X	X	X	X				
PA-O	No Information Provided								
PR	No Information Provided								
RI	X	X	X	X	X	X	X		X
SC	X	X	X	X	X		X		
SD	X	X							
TN-M	X	X	X	X	X			X (5,000)	
TN-O	X	X	X	X	X			X (5,000)	
TX	X	X	X	X	X	X	X		X
UT-M	X	X	X	X	X				
UT-O	X	X	X	X	X				
VT-M	X	X	X						
VA	X	X	X	X	X		X		
VI	No Information Provided								
WA-M	X	X	X	X				X (20,000)	
WA-O								X (20,000)	
WV-M	X	X	X	X	X	X	X		X
WV-O	X	X	X	X	X				
WI	X (only if hospital actions resulted from peer review)	X	X	X	X	X	X		
WY	X	X	X	X	X	X			
Totals:	53	52	49	46	45	23	26	12	21

Chairman STARK. Dr. Wilbur.

STATEMENT OF RICHARD S. WILBUR, M.D., CHAIRMAN OF THE BOARD, AMERICAN MEDICO-LEGAL FOUNDATION, AND EXECUTIVE VICE PRESIDENT, COUNCIL ON MEDICAL SPECIALTY SOCIETIES

Dr. WILBUR. Thank you, Mr. Chairman.

It is a pleasure to speak on this bill. The American Medico-Legal Foundation was formed to insure the quality of medical care which this bill intends to support. We want to support the intent of the bill that Medicare recipients receive care only from qualified doctors and HCFA make payments only to qualified doctors on behalf of those patients.

Unfortunately, this bill does not measure many of the appropriate and essential qualifications of medical practice. There is another approach already in place, peer review, which is not perfect but is improving and which with your help could be better.

The purpose is not in dispute. There was a time when the medical profession was not that interested, there was a "protect everyone" attitude, but I don't think that attitude exists today, certainly not in the specialty medical societies that are attempting to define guidelines. This bill is expensive, involves all physicians and fails to measure essential elements of medical practice, the skills such as those of surgery, use of equipment, and interprofessional relationships. Health care is no longer an individual matter. It is a team matter. It involves patient relations, the ability to communicate, listen to the patient and to enable the patient to comply with the drugs and other regiments. It takes compassion, concern, and the proper attitude. The proposed test does not measure the cultural effects such as divorce, children, using drugs, and honesty. It is not a valid test for what it is that you so appropriately want to measure.

Let me use an example out of medicine. The bar examiners in this country were concerned a while ago that the American people thought the term "legal ethics" was an oxymoron. To prove to the public that lawyers were honest, they set up the Multi-State Professional Responsibility Examination which I had occasion to take last month. In Illinois the passing score is 80.

Mr. Chairman, does the fact that I got 127, in any way make you feel that I am more ethical or believable a person or does it tell you that I went out and paid money to a testing center to listen to tapes and get a booklet to study?

My concern about the Secretary's examination is that it, too, would be developed by experts, in my case, by the best and brightest gastroenterologists, then centers would make the tapes and I could watch the tapes and pass. I am 20 years out of practice. Groucho Marx said he would not join a country club that would have him. As for me, I would not practice in a hospital that would accept me based on my examination results.

The real difficulty though, with the Secretary's test is that there would be competent gastroenterologists far from a testing center, too busy working to bone up on how to answer these clever questions. What if she scored 79 when the passing score is 80? Her Med-

icare patients would be deprived of care they deserve and could no longer get. We in the American Medico-Legal Foundation feel it is better to rely on the actual assessment of performance as you have heard from previous speakers. This is mandated by the joint commission, HCFA, PRO's, and hospital bylaws. The system is already in place. It is congressionally supported by the Health Care Quality Improvement Act of 1986, Public Law 99-660. It is improving.

The specialty societies are busy developing guidelines for better practice, the American Medico-Legal Foundation is helping hospitals to implement these guidelines locally by providing impartial peer review. If the peer review system needs more help and the fact that it has problems, as you said, is true, we note the problems of the rural hospitals who do need to have the impartial peer review they cannot get locally provided for them.

To the end of supporting the concept of this bill and carrying it out through even better peer review than we have had in the past, we at the AMLF would be delighted to work with you and your excellent staff to achieve this worthwhile goal.

Chairman STARK. Thank you.

[The statement and attachments of Richard S. Wilbur, M.D. follow:]

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House Ways and Means Sub-committee On Health

HR-4464 "Medicare Physician Qualification Act of 1990"
April 23, 1990

Testimony of American Medico-Legal Foundation
Richard S. Wilbur, M.D., Chairman of the Board

Chairman Stark, it is a pleasure to appear before this committee to comment on this important subject. I am Dr. Richard S. Wilbur, Chairman of the Board of the American Medico-Legal Foundation (AMLF). The Foundation is a non-profit, tax exempt organization founded by leaders of medicine and law to furnish the impartial peer review called for by the Health Care Quality Improvement Act of 1986 (PL-99660).

The American Medico-Legal Foundation was formed to assist hospitals in assuring the adequacy of the quality of health care given to their patients. The purpose of HR-4464 seems to the AMLF to be the same as the purpose for the AMLF, to assure quality. The AMLF agrees with you, Chairman Stark, that Medicare recipients deserve the assurance of good medical care. Moreover, Congress deserves the assurance that the large sums of money spent on Medicare recipients is spent appropriately. The same laudable goals, the same desirable ends are desired by both AMLF and the author of HR-4464. It is only when we discuss the methods to obtain this goal, only when we consider the means to this end that there is any variance.

HR-4464 would require a certification of the qualifications of physicians through examinations. These examinations are to be under the supervision of the Secretary of Health and Human Services. They are to ensure a knowledge necessary for the practice of a competent physician in the general practice of medicine or osteopathy or in a field of specialty in medicine or osteopathy.

The concept behind this legislation is commendable. Unfortunately, the mechanism for accomplishing the goals is not well proven. The theory behind the examination of physicians is that there are characteristics of medical practice which are required for competence in medical care and that these characteristics can be evaluated by examination such as multiple choice questions (MCQ). Therefore, theoretically, a physician who fails to answer a sufficient number of multiple choice questions correctly is incapable of practicing adequate medical care. Contrarily, the physician who answers questions successfully is competent. Unfortunately, there is no good validation of this theory. It is certainly true that one cannot practice successfully without knowledge of medicine and without knowledge of the rapid changes occurring constantly in this rapidly evolving field of medical care. In judging whether or not a physician should continue to

practice his/her specialty requires one to look at qualifications and competence. That should determine hospital privileges, not whether the surgeon gets an A or B in an examination. However, the conclusion that persons who do well on MCQs are performing competently is not necessarily true.

The national specialty certifying boards belonging to the American Board of Medical Specialties are able to test for that knowledge which a specialist in a given field should have acquired through an adequate training program as described by that specialty board and by that specialty residency review committee under the auspices of the Accreditation Council For Graduate Medical Education (ACGME). The specialty board certificate, however, does not certify competence or capable performance. It certifies successful completion of a prescribed course of training in that specialty. Furthermore, failure to pass that certifying examination does not bar a physician from the practice of medicine as long as the physician can pass the requirements of the State Licensing Board. Therefore, that the physician who is competent to practice but who does not take specialty board examinations well will still have an opportunity to care for those patients who could benefit from his or her care.

The examination contemplated by HR-4464 would prevent Medicare recipients from availing themselves of the services of a physician who failed the examination prescribed by the Secretary. The results of the examination mandated by the Secretary would be far more crucial to a physician's ability to care for Medicare recipients than would the failure to pass a certifying board. It is, therefore, essential that the examination be valid; that is, that the examination be able to exactly measure those qualities which are essential for the physician to practice for a level of care worthy of payment from Medicare funds.

This examination does not even have available the type of information required by the specialty certifying boards before allowing the applicant to take the examination; that is, the careful observation by professors during medical schools and by senior attending physicians during the residency. These are observations of the applicant in action. The certifying boards need assurance of competence in action, as well as the passage of the test.

It is well known that the ability to take an examination is not well correlated with the ability to perform. While it is probably safe to predict that a person who passes high on a test will perform better than one who scores very low on the test, the critical question comes at the cutoff point between the "pass" and "fail." That is, the relative abilities to care adequately for a Medicare recipient between the person one point above the cutoff and the person one point below. There may well be some good examination takers who do not give satisfactory health care. The converse is also true. There are undoubtedly a number of physicians who are able to practice satisfactorily within their areas without the knowledge required to pass examinations which have been developed in large Eastern cities by the leaders of American medicine. The questions of great importance to the examination of young residents in a tertiary care hospital are not necessarily the ones crucial for caring for an elderly person in a rural setting. The data necessary for one clinical specialist will obviously be different from the needs of another, even in general practice; e.g., some general practitioners spend much of their professional time in Obstetrics and Gynecology. An examination which decides who should care for Medicare recipients on the basis of answers to questions developed by "the best and the brightest" is all too likely to deny a Medicare recipient in an isolated part of the country any medical care whatsoever. To the extent that the examination was irrelevant to that physician's ability to take good care of that Medicare recipient, this would be a tragic result from an otherwise laudable endeavor to assure the recipients of satisfactory quality care.

There are efforts currently under way to develop satisfactory clinical skills examinations. Unfortunately, these are still in development, still being evaluated, and still short of the validation required for the momentous decision as to whether or not a Medicare recipient should be denied care from a given physician. They have the added drawback of being extremely expensive.

Since the goal of HR-4464 is laudable, and since currently available examinations are not adequate to make the exquisitely important decision as to whether or not the physician should be allowed to care for a Medicare recipient, must we then abandon the chairman's aim of reserving Medicare payments only to those physicians who deserve to receive them?

Not at all!

The American Medico-Legal Foundation is committed to the proposition that these distinctions can be made. The AMLF believes, however, that there is a better way.

This is the path of peer review. It has the virtue of already being required by not only the Joint Commission on Accreditation of Health Care Organizations, but also by the Health Care Quality Improvement Act of 1986 and many state statutes. It is the subject of Health Care Financing Administration regulations and has been in place in this country for decades. That the system has not always worked adequately is far from a secret. The AMLF recommendation to the committee is, however, that system be improved rather than supplanted by an examination.

There are, at present, professional initiatives to do just that. multiple organizations, including the specialty societies which are members of the Council of Medical Specialty Societies, are working to develop implementable guidelines for health care. Simultaneously, hospitals, encouraged and stimulated by the Health Care Quality Improvement Act, are tightening up their peer review procedures. The advantages of peer review over written or even observational examinations are that peer review measures the physician in action. This measures what he or she does when faced with real problems. Peer review surveys those problems in judgment, in inter-personal relationships, in the presence or absence of compassion, and in the ability to perform under stress that are not measurable through examinations. Very little--especially in the surgical specialties--can be determined by written or oral examination. Most suboptimal performance is a failure of skills rather than one of knowledge. Skills are more difficult to test. A physician may know the right answer to an examination but the important question is whether or not he/she performed the right way. Moreover, many physicians do not fail in their own specialty, but when they try to treat outside of it.

The early years of peer review were marred by inadequate evaluation guidelines. This is now being addressed aggressively by specialty societies and others. These years were marred by inordinate delays due to frequent lawsuits by unhappy doctors. This has been well addressed, not only by the Health Care Improvement Act (HQIA) and state statutes, but also by a series of judicial decisions which have defended good faith peer review, while, as in the Supreme Court case of Patrick vs. Burgett in 1988, slapping down with severe penalties bad faith review. The difficulties in obtaining impartial peer review to be certain that the decisions are made in good faith are being solved by of the American Medico-Legal Foundation and a number of concerned specialty societies.

What is required then is a systematic review of a significant percentage of all patient medical records--a peer review of the physician's performance. Only then will there be sufficient data to show deficiencies.

The American Medico-Legal Foundation, which I represent here today, has almost a three-year experience in hospital and medical-staff peer review. We are attaching the Foundation's brochure, for your information.

It has become evident that while some reviews are competitively motivated, AMLF's type of peer review does indeed reveal not only where there are deficiencies in quality but, moreover, suggests the areas when the individual M.D. can obtain beneficial remedial education. Since most medical care is interventional, the "testing" of physicians every few years will simply not reveal any usable practical information to assist in either cost containment or general medical care.

The review of office performance is not as well developed. Fortunately, this is not an area in which the quality of care is as critical as it is in the hospital setting. Furthermore, the technology for the review of office records is developing. While it is still too expensive, the ongoing development of computer models and of guidelines will continue to make this review more successful and most cost effective.

The AMLF suggests that the Committee's attention be directed at means of helping hospitals, particularly the smaller and more peripherally located ones, in obtaining this essential impartial peer review. Many hospitals over 150 beds are able to pay for outside independent peer review for those physicians who show deficiencies. The serious problem in the United States are the smaller community and rural hospitals that simply cannot afford outside impartial peer review. This is discussed in a recent article, which is attached, from the magazine, MODERN HEALTHCARE.

In conclusion, Mr. Chairman, the AMLF applauds your continued concern with the quality of medical care. The AMLF joins with you in pursuing a line of definition between those physicians worthy of Medicare payment and those who are not. The AMLF does respectfully suggest that continued improvement and support for the presently mandated system of peer review would be more successful in distinguishing between adequate and inadequate physician performance. That it would be more economical, and it would be less burdensome. Finally, it would be more fair to those Medicare recipients who deserve to have a caring, competent physician whether or not he or she is an expert at taking tests.

Thank you for the opportunity of appearing before this hearing on this vital subject.

RSW:cmb

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AMERICAN MEDICO-LEGAL FOUNDATION

Purposes and Procedures for the Assessment of the Quality of Care

1990 - 1991

THE BARCLAY
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The Purpose

The American Medico-Legal Foundation is a national non-profit corporation which provides independent and expert peer review of physician performance by an impartial assessment of the quality of care. The process provides confidential medical and medico-legal opinions to hospital trustees, boards of directors, hospital counsel and peer review committees, to help resolve the dilemma institutions face in balancing their responsibility for quality of medical care and patient safety with the individual rights of staff physicians. It also provides assurance to physicians under review that the process will be fair and impartial.

The Foundation

The Foundation was incorporated in 1987 in response to the 1986 "Health Care Quality Improvement Act (P.L. 99-660)" which creates immunity for peer review done in good faith. It is headed by a Board of Directors notable for their expertise in clinical medicine, education, health care delivery, institutional accreditation and health care law. The Board is broadly representative of medical disciplines and includes past presidents of the American College of Surgeons, the American College of Physicians, the Joint Commission on the Accreditation of Health Care Organizations, the American Hospital Association, the American Academy of Hospital Attorneys, and the American College of Legal Medicine. The Executive Director, a pharmacologist-lawyer, supervises the Philadelphia headquarters.

The Peer Reviewers

The methodology established by the Board provides from one to three reviewers for most cases. The Foundation has the cooperation of recognized senior clinical specialists, representing all areas of practice and all regions of the United States. These practitioners have been carefully screened by the Board of Directors for their preeminence in upholding the clinical standards of their specialties. In addition, the Foundation calls upon a select group of physician-lawyers representing all specialties and most subspecialties. To insure independence and impartiality, reviewers are selected from a different state than that of the requesting institution.

Peer Review Procedure

A hospital wishing peer review of clinical performance provides a detailed statement outlining the concerns regarding the physician's activities and privileges. The letter should include the credentialing file and curriculum vitae. It should also provide all pertinent data regarding the health care facility such as the type of institution, number of other physicians in the relevant specialty and on the total staff and any other information bearing on the physician's performance.

To insure a satisfactory review of the physician's practice performance, the peer reviewers must evaluate an adequate number of charts. The number of records necessary for review is related to the number of questionable judgments or procedures performed by that physician. It must be large enough to establish the pattern of clinical practice. Because a few case records can rarely delineate a physician's ability to perform, a statistically sufficient percentage of the year's charts is necessary. This can vary from ten to one hundred records. A telephone call to our Executive Director may be helpful in determining the appropriate selection.

All relevant documents should be included, such as the complete medical records, autopsy records and incident reports. Copies of X-rays should be included, if pertinent to the quality of care. In obstetrical reviews, copies of all fetal monitor tracings should be included. Each chart should be copied, taking care to ensure that the entire file is readable, and enclosed in a separate folder or envelope. Color separators should be used to identify sections of the records. Because the records will be shipped several times, it is important that all documents be copies. The Foundation cannot accept responsibility for originals.

These submitted documents are carefully reviewed by an eminent senior clinician selected by the Foundation as a recognized authority in the specialty of the physician under review. This type of review is usually performed when the question is whether the quality of care is at an acceptable standard. In addition, an overview by a physician-attorney certified in the same specialty is available for hospitals who wish a second clinical review combined with a medico-legal perspective. A final combined report is then forwarded to the health care facility.

Other forms of review are also available. Sometimes the review is done by two or more senior clinicians, who divide a large number of records or who consecutively and independently review the same records. When serious disciplinary action such as revocation of privileges is being considered, we recommend two independent senior specialist reviews. In addition, the physician-attorney-specialist overview is available. The hospital should also consult with its own legal counsel.

Objective On-Site Appraisals

The Foundation can also provide a review of several individual specialists or entire specialty departments. These reviews include prior chart analyses, followed by a one-to-three day visit to the facility by a team selected by the Foundation and agreed to by the hospital. During the visit the Foundation reviewers will interview administrative officers and appropriate members of the medical, surgical and nursing staffs. They will also tour the facility. An on-site visit will enable the reviewers to make an objective examination of patterns of patient care and offer recommendations to institutions with internal conflicts. This type of review has proven helpful in the mediation of staff problems that appear to be both clinical and interpersonal, by providing an objective review by experienced outsiders with no personal interest in the outcome.

The Report and Recommendations

The report analyzes every record with individual critiques. The clinician writes a report about each case that is directly responsive to the questions of the hospital. There is then a summary of the principal findings and appropriate practical recommendations for hospital action. When two physician specialists have simultaneously but independently performed a review of the same records, both reports are forwarded to the Foundation. A combined document is then sent to the health care facility. When requested, the reports and individual care records may be reviewed again by another physician certified in that specialty who is also an attorney. In addition to providing another peer review, the physician-attorney gives an additional perspective based on his medico-legal experience.

Following a site visit and careful evaluation by the review team, the final written report offers practical recommendations for positive change to improve the department's quality of care or possible solutions for internal conflicts. If several options are available, they are listed for the hospital's consideration. The hospital's legal counsel should be aware of the review and recommendations.

The length of time between the submission of data by the hospital to the receipt of a final report is usually two months.

Fees

The cost of reviews are covered by the submitting hospital. An initial deposit of 1000 dollars is requested at the time that records are submitted for initial review. The reviewers are compensated at a rate of 200 dollars an hour and the total charges are based upon the amount of work done. The institution is billed for the balance when the report is submitted.

Validation of Physician Credentials

The Foundation will undertake the validation of credentials of physicians seeking staff positions or hospital privileges. It will also provide assistance in the development of procedures and forms.

Hospitals and other health care facilities have the responsibility for assuring the professional competence of staff physicians. Institutions must require, as a condition for granting of privileges, that a physician document not only experience, training, demonstrated competency and reputation, but also adherence to the ethics of the profession. In the last decade an increasing number of instances have been reported of the submission of misrepresented or fraudulent evidence of training, certification, or licensure. Therefore, the review of applications for new or renewed privileges should be rigorous and thorough, while also providing procedural and substantive safeguards. The assistance of a group beyond the influence of the institutional structure may be needed. The rates for this service are available upon request.

Independent peer review often too costly for clients

By David Burda

A not-for-profit foundation created to perform independent peer reviews for hospitals and physicians costs too much to be useful to the small and rural hospitals that need it most, the foundation's chairman admits.

Hence, the Philadelphia-based American Medico-Legal Foundation will seek external funding this year to offset the cost of using the foundation to settle peer review disputes at hospitals, said Richard Wilbur, M.D.

A group of 10 attorneys and physicians in 1987 created the foundation, which contracts with about 500 "expert" physicians to perform independent peer review for hospitals and physicians who can't do it for legal or political reasons.

The foundation's peer review decisions aren't binding on a hospital or a physician, but they do provide an objective analysis of a physician's work that the hospital can use to make difficult peer review decisions.

The foundation's peer review proceedings are confidential, and the organization doesn't release the names of hospitals or physicians involved in peer review disputes.

Prohibitive costs. Providers that use the foundation's services pay a $1,000 application fee and $200 per hour for a physician reviewer's time. The providers also pay the costs of mailing medical records to a physician reviewer or paying the reviewer's expenses of traveling to a hospital to examine records on site.

During the past two years, the foundation has handled just 65 peer review cases on behalf of providers.

Dr. Wilbur said the least expensive bill was $3,000, for the review of a handful of records to determine whether a physician used too much blood during surgery. The largest bill was $65,000, for the review of hundreds of records to determine the quality of care provided by an entire medical department.

Clearly, the price can be prohibitive for small and rural hospitals, which often are confronted with touchy peer review cases because of their size and location, Dr. Wilbur said.

However, the foundation has no data on the types of hospitals that have used the foundation's services or on the types of hospitals that have avoided the foundation because of cost.

American Medico-Legal's Dr. Wilbur

Review obstacles. Regardless, from a political and legal standpoint, peer review at a small or rural hospital can be difficult because of the small number of physicians, medical staff experts said.

At one extreme, the physicians may stand by each other and refuse to disclose possible quality problems to the hospital. At the other extreme, the physicians may dislike each other, making it difficult to obtain an objective peer review decision without charges of economically motivated mudslinging and threats of antitrust lawsuits.

To complicate matters, the few physicians in the area may not have the expertise to adequately review a peer's performance.

All except two of the 65 cases that the foundation has reviewed were requested by hospitals. The other two reviews were requested by physicians who believed they were being maligned by hospital peer review committees, said Evelyn Baram, an attorney and the foundation's executive director.

In one case, a physician was up for reappointment to a hospital's medical staff, and he wanted evidence to refute charges that his care was below acceptable levels, Ms. Baram said.

At personal expense to the physician, the foundation's reviewers examined records from 85 patients treated by the physician. In just eight cases, criticism of the physician's care was legitimate, but his practice habits in those cases could be corrected easily through education, Ms. Baram said.

"The case had a lot to do with politics from other doctors," she said.

The foundation hasn't heard from the hospital regarding the physician's reappointment decision.

In fact, the foundation's reviewers have found instances of poor care by physicians in only about one-third of the cases, Dr. Wilbur and Ms. Baram said.

About two-thirds of the cases either involved a physician whose practice habits were safe but different from his peers or physicians whose peers disliked him and who tried to discredit him with allegations of poor care.

Unbiased opinion. That's why a 600-bed Pennsylvania hospital has retained the foundation. The hospital's medical director spoke on the condition of anonymity.

Nearly two years ago, four surgeons who were part of a group practice at the hospital broke up over a personal dispute, the medical director said. Two physicians formed their own group practice, and the other two physicians are practicing alone. The four surgeons constitute the entire staff of one hospital medical department.

Since the breakup, the surgeons continually have accused each other of poor care, hurting medical staff morale in the process, the medical director said. The accusations continued even after the department's chairman reviewed the physicians' work and found no quality problems.

"We had to turn to an outside agency for an unbiased opinion," the medical director said.

The hospital recently sent 48 patient charts to the foundation concerning care provided by the surgeons from January through June 1989. The hospital expects to receive the results from the foundation shortly.

The hospital expects to pay $5,000 to $10,000 for the review, said the medical director, who believes the money is well spent.

"If the external review confirms that the care is fine, we'll sit the physicians down and tell them to shape up or ship out," the medical director said. "If the accusations are true, we'll take other corrective action." ■

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have no questions, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Dr. Winn, I noticed that you opposed this legislation and Dr. Wilbur I presume also opposes the specific legislation. I can understand your concern that it might be the first step in passing a Federal standard as opposed to a State standard.

Dr. Winn, you emphasized that you think a better approach is to identify the problem physicians and to follow a procedure that would require some kind of mandatory reporting or possible disciplinary action. Is that what you do in our State of Texas?

Dr. WINN. I am not certain that I would want to use the term disciplinary action. I think, however, if you say that the weight of the action or the request that the medical board makes, that implies they can revoke a license and in fact it would be disciplinary. I believe the focus is to first identify the problem physicians, determine whether or not that physician could be improved with remedial training and attempt to, first of all, protect the public from such a physician and restore that physician to an active practice situation.

Mr. PICKLE. I understand that your association encourages reporting or identification of any physician who might not be up to date. Is the system working within the State of Texas and in other States?

Dr. WINN. Yes.

Mr. PICKLE. How widespread or effective is that?

Dr. WINN. This system has gained acceptance in the majority of States today; not all States and not all boards follow the system, but we well over half of the boards follow it in a fair degree of detail. It is gaining more and more recognition.

The medical boards have had this ball passed to them in the last 10 years of having to focus more on quality assurance than they did in the past. They are accepting that responsibility. They have to set up and retain the tools with which to do their jobs from the State legislatures. They have to have the appropriate status and funding. They are coming along very well in this system.

Mr. PICKLE. Are you telling me that over half the States now have this kind of a problem physician approach?

Dr. WINN. Yes, sir. They require on reregistration some type of identifiers that would help that medical board identify which physician it is that may need further testing and evaluation.

Mr. PICKLE. Can you give the committee that data? I would like to see it.

Dr. WINN. Yes, sir. It was attached to the testimony that I provided to the committee.

Mr. PICKLE. All right.

Dr. WILBUR. In Texas in 1984, 23 physicians were identified as not practicing appropriately by the Texas PRO. It was the University of Texas at Houston which was the first in the country to set up a remedial process of identifying what the problems those physicians had were and what could be done to return them to practice after appropriate help.

Mr. PICKLE. Are other States following the same approach and, if they are, is that a substitute or an answer to this proposal?

Dr. WINN. Mr. Pickle, I believe we are making a lot of progress in getting all States to follow this program. I believe it will be an acceptable substitute for this legislation that is being proposed. It will enable the medical boards to use those resources. You know as well as I do that those resources are very limited, to use those resources ineffectively to deal with the problem physicians rather than testing physicians where the great majority are going to be certified as being appropriate.

Mr. PICKLE. I take it that your organization or your State would not favor Federal minimum standards for State licensing programs. Is that essentially correct?

Dr. WINN. Yes, sir, I believe that is the job to be done by the States.

Mr. PICKLE. Even your own standard?

Dr. WINN. Yes, sir.

Mr. PICKLE. All right. Thank you.

Chairman STARK. I am concerned about some sort of minimal standards here. Would any of the members of the panel conceive of any condition under which a physician under the influence of alcohol should be allowed to practice or could be allowed to practice? Is there any reason to tolerate that? Is there any reason to think a physician who used cocaine should be allowed to practice?

Dr. WILBUR. You mean in the past or currently?

Chairman STARK. In today's understanding of crack/cocaine, anybody who uses it once is very apt to use it again. But there are no standards under which any State would refuse to relicense a physician if those two issues were the case.

Dr. WEARY. I will comment about that, if I may. We have seen an exponential increase in the number of impaired physicians who are delicensed or put on provisional capacity in some way or another, an exponential increase in the last 15 or 20 years. It has been extraordinary. I get board briefs periodically about once every 3 months.

Chairman STARK. I don't mean to attack the community. I am suggesting that the system as it exists is not sufficient. For example, here is where the logic of the present system comes apart. In 1987, New York had 306 actions against doctors, Florida had 202 actions against doctors and California only had 144. I would love to tell you that all the doctors in California are better than the ones in New York or Florida, but New York has 10,000 fewer doctors and Florida has 40,000 fewer than we do. There is some complaint going on in my State now that it is just too much of an old boy network, that doctors will not punish other doctors, often for fear of retribution in the courts, liable cases and some financial risk to the reviewing physician.

I guess I am looking somehow to see the FLEX-SPEX thing, of which I don't know anything about. I just heard about them a moment ago. But is there a minimum level, understanding that knowledge to pass a multiple choice test may not qualify somebody to do open heart surgery but ought it not as a minimum be an entry level exam?

For specialty situations, there should be additional. Are there some minimum levels both on personal ability or impairments that ought to require a vacation until you either can prove that you are

competent or cured if that's the case. I look at airline pilots, none of us here are competent to decide whether any one of the six of us could fly a 747, but I don't want to get on a plane and take Jake Pickle's word that the pilot can fly it. He won't take my word. We need to have somebody who can fly the 747.

Ought there to be some very minimal standards, and secondly, ought not the burden of proof rest on the individual practitioner and not on the review commission? Those are the two keys, are they not?

Dr. WEARY. I would like to share with you my thoughts about how knowledge fits into this whole scheme.

Chairman STARK. I would like to lump knowledge and skill which takes interpretation together.

Dr. WEARY. I will share with you a scheme I came up with a few years ago. I would say that knowledge, skills and training are essential, major components of qualifications, and this is what we do when we certify the individual initially. Then qualifications which include knowledge, skills and experience along with judgment and common sense, are major components of competence.

But competence must be combined with consistency—do you do it regularly? You can be very competent, but if you are only competent part of the time then it is not going to count. Competency, consideration of patients—being concerned about the patients—are major components of performance. Performance then must be combined with perseverance and opportunity—you have to have an opportunity to get a good result—and these are all components of outcomes. What we should be looking at in the long run is performance and outcomes. Now performance is going to be what you can best judge from peer review probably. Some of these components we can evaluate well and some we cannot.

But they are all components of performance and outcomes in the long run.

Chairman STARK. Go ahead, doctor.

Dr. WINN. To respond to several specific issues you raised a moment ago, regarding drug addiction or being impaired by the use of alcohol and other substances, those physicians are difficult to identify just as airline pilots are difficult to identify. However——

Chairman STARK. Random testing.

Dr. WINN. That is fine. I did not see that in your bill, the point about random testing. But be that as it may and if random testing is involved, over 30 of the States currently require that to be reported to the medical board. Therefore, those physicians would be subject to reevaluation and retesting to be certain that their cognitive abilities have not been impaired by that abuse and that they undergo specific remedial education, training, whatever to be certain that problem does not continue.

Chairman STARK. My example: the guy tests with a 0.10 on a random alcohol test and he is about to go into surgery, in my book he is impaired. In my book if it is a random test and a guy is going into surgery with that much booze, he should be out of the game until at some point a very strenuous review would certify that this person has a severe problem and has corrected it.

There is a finite difference from revoking someone's driver's license and they have to go back and do the training and pick up

trash by the side of the highway or go to the rehab course at which point they then get their license back.

It is really a question of whose responsibility it is. I don't know if you get a bunch of guys who want to investigate—we see it here in the House. Some of us are called on to investigate our peers. It is no fun. Nobody likes it. Nobody likes to take the job, nobody likes to do the job.

But it seems to me that they ought not have to prove somehow that what they are doing is right. If there is a case and somebody breaks the rules, they ought to prove they are worthy to come back in. Those are the finite differences but I see it happening in that they find the bad apple, the guy who has been convicted in one State and then he moves to another State and they still cannot stop him.

That seems to be one of the weaknesses in the system that I think everybody agrees we should tighten. I am trying to find out how we can help you all do that.

Dr. WINN. The system should be tight enough to never allow a physician to practice impaired. I believe we are moving that way. You mention that California's actions were somewhat less than New York or Florida. In our survey we took recently asking medical boards to respond as to what markers or indicators they utilized, California did not respond that any markers were in place. There may be a conclusion you can draw from that in the fact that they may not be identified some of the physicians that they should identify.

The specialty examination regarding clinical information, cognitive information of clinical value. In many States utilizing that to help test these types of physicians that we are talking about who have shown up through the use of markers and indicators to need some type of other evaluation.

My point about the PRO's should not be lost. This is a valuable source of information to medical boards. Medical boards should not be at the very end of the loop in this situation. When the PRO's who are out there looking at the performance of physicians on Medicare patients are found not to meet standards, they should be identified to the medical board.

Chairman STARK. OK. The PRO is a board of primarily physicians, right?

Who decides who will sit on a peer review board reviewing doctors, other doctors?

Dr. WINN. Ultimately, the quality assurance committee comprised of physicians is the one that makes the final determination; that is correct.

Chairman STARK. OK.

Now, they have to sit, and if you are up for relicensure or recreditation, call it what you will, it seems to me that if they are going to censure you or remove your license they have to somehow prove that you don't measure up.

And what I am wondering is if we just shouldn't reverse that, given a minimum standard of activity, as you suggest. In other words, if you are only up every 7 years, you ought to prove that somehow you practice something in 7 years.

It seems to me that it's a lot easier if every physician knows there is a minimum that he or she is going to come before this group once every 7 years, and they will bring their list of cases with them, and they are going to bring their credits from their home study courses, or they are going to bring a recommendation from whomever, I don't know.

But they are going to come in and say look, peer review board, I did these things, and as a minimum, you have to give me my license again or to accredit me.

I took the test again, but I also had this much experience, and I learned this new procedure, and I had these kind of results.

It seems to me that a better standard might be to put this responsibility on the practicing physician, and then as part of their practice, they will constantly be thinking about the next 7-year period when they come up again and they will keep these records and perhaps be a little more conscientious as they go along.

Does that put us in a better position? Does it put you in a better position to do your job, Dr. Wilbur? What do you think?

Dr. WILBUR. Yes. I was trying to think that what you are proposing which is to bring in one's own patient records, I initially thought you were thinking of an examination, cognitive examination.

Chairman STARK. I think whatever you all decide ought to be about the examination. That is up to you to decide, whether it ought to be a review of the person's experience, or testing him for judgment. It's like going through a thesis examination. People test you verbally on what you would do, which is different.

Some people don't write very well. Some people don't respond verbally very well. It would seem to me three or four physicians questioning somebody who wasn't their friend would make it very difficult for the individual.

Somehow that puts the peer review people in a better position, and they are not always being the sneaky SOBs who are trying to follow them around and get them in trouble.

Everybody has to do it. It isn't like you are being called up to be punished. It's almost like being called to the grand jury; you are guilty before you even get in there.

If everybody goes through it, it becomes part of the accepted professional protocol and therefore is not a black mark.

As I said, that is the difference that I meant. Lawyers have a basis for that. Sir?

Mr. PICKLE. Why don't I make an additional observation.

It seems to me that members of this committee and members of the panel would all agree that it's very important that each practitioner maintains a level of competence. I don't think any of us wants somebody to be practicing who is really not capable, or who has fallen behind or is out of date or physically or mentally not able.

Now, we can achieve it through a measure like Mr. Stark proposes, or through PRO systems, through identifying problem physicians or through education or through automatic reexamination or any number of ways.

I think it's important that physicians, as a whole, try to match the best way they know within their area of medicine and for the

patient to come up with the best approach that we can take. This is a good one because it puts the responsibility specifically right back to the doctor.

You have either got to help us get a standard to show that competency is being met, or else we are going to do it for you. And I would hope that the States could do it, but the onus is on you.

My concern about the overall approach we see discussing today is that if we take this approach, it seems to me like through the back door we are trying to set a Federal standard, that we are relating it to the practice of Medicare, that we are going to question physician competence only as it relates to Medicare. And if it wasn't for Medicare, we wouldn't be concerned about it.

And I think the chairman is worried because the Medicare costs are getting so high and uncontrollable in many respects that we have got to find some way to try to cut them back. This might be one way to do it.

So the question is, would you relate all this to Medicare? We don't do that for physicians or engineers or dentists or any other group that I know of. But that is not to say that we cannot require more in the field of medicine, because this is our immediate problem, the cost of Medicare.

Now, that is what we have got to try to solve. Can we come up with a good system of testing the competence and credibility within your profession, or do we need to establish Federal standards through the back door to say that is going to not only control in some way the cost of Medicare, but you also set up Federal standards.

And the question is, should it be done here or on the State level? And I think that is something we have got to study. I don't think we need to establish Federal standards as long as you do your job.

Chairman STARK. If the gentleman would yield, I think you hit on a point. I would ask the panel, doesn't the quality of licensing boards vary from State to State?

Dr. WINN. Yes, sir, it does.

Chairman STARK. Really, aren't there a few States that presently and historically have never taken any action against doctors?

Dr. WINN. I don't know of any board who have never taken any action, but there are some boards that are certainly weak that we do not feel are up to speed.

Chairman STARK. To answer Mr. Pickle's question, what if we took some of the States in the middle, not the ones that you guys would say have the toughest, most strict test, but we just took 15 States who are generally OK, put them up on a board, throw a dart at them and took one of them and said, these ought to be the minimum standards for all the other States to have to meet?

I think that is the difference. I think I would have no quarrel with my colleague from Texas about letting the States do it, but the fact is some States don't do it at all and some States do a lot more and get a lot more involved.

Somehow if you take a minimum standard of what people think ought to be done, then if States want to do more, or do it differently, then let them.

There are questions of some States being underfunded for this organization, because some State politicians don't care much to do it.

The local doctors don't want it done, because it's a little inconvenient, so the politicians don't raise any money to do it.

We have heard complaints in that regard, and I guess I don't quite know how to measure it.

Dr. WILBUR. If I may suggest that what we have been discussing is what you discussed was a test for competence, whether a person is able to do something, and what we are speaking to is the real test is did he or she do the right thing in performance.

You have suggested——

Chairman STARK. Doctor, I think I can even get it down to a much lower level. I guess it's a test and a procedure for incompetence; and there doesn't seem to be a way, when you have got this beautiful choir of physicians out there, some singing high, some singing low, some singing soft.

One cannot sing any better than I can. We ought to get him off stage and not let that one person spoil this beautiful orchestration.

We had in California a case of a guy who was convicted of murdering nine babies, and he kept his license while he was out on bail awaiting sentencing. Then his practice was taken over by a guy who was subsequently arrested on 10 felony counts of furnishing illegal narcotics.

Now, those are horror stories. Those are awful anecdotes, and I don't mean to brand a profession. But what I am suggesting is that even for that, there is no way to get those guys out of the action until they somehow show that they are serving time or whatever else they have to do and then going back to school to get up to speed.

It seems there ought to be a minimum way to remove those people who by your judgment should not practice. I am sure everybody who has testified and will testify here today would say yes, there are a few who shouldn't practice.

Now, how do we together get those guys out of the action until such time as they can redeem themselves or find another profession or just run for Congress. We are not looking for a rating system. I don't think that is possible and certainly not desirable from our standpoint.

But how do we help you all continue this screening process? I make no bones about it, that this is just a Medicare idea. I would be the last one to be so disingenuous to suggest that if this were a good idea for the seniors in our country, it certainly would be a good idea for the rest of the citizens.

I would like to figure out a way to do it. Obviously, it's not going to work unless, gentlemen, the people you represent would do it with us willingly.

This is not the kind of thing that we can force at the Federal level. I don't think that just having a Federal minimum standard hurts. What I am trying to see with you is if it wouldn't help. If that's the case, then how?

Dr. WEARY. Mr. Chairman, you heard from Dr. Gellhorn earlier about the initiatives in New York State, which I personally feel are very good and general and forward looking.

I think that one of the things that would be very helpful would be to encourage the States, through either monetary support or

whatever, to develop the type of innovative proposals that New York State is doing.

The big question, I guess, is whether it's best to do this through a Medicare process or not. And our concern about whether doing it through the Medicare process is that it may make access problems.

That has to be understood because—and I think that a study of this would be very important because there may be many communities where a number of physicians may either choose not to apply or they may fail the examination process, and then your Medicare patients are without physicians there. And I think that is a real concern.

But I would suggest that there are other ways to look at how to improve the type of innovative process of New York State and some of the other States are looking at. And I think that is one thing that should be carefully thought about.

Chairman STARK. Well, as I say, if New York State has the right answer and is broadly acclaimed by professionals and Government officials alike, then why shouldn't it become the law of the land to bring some of the laggards like California kicking and screaming into the 21st century, or the 20th century, before the 21st century is upon us?

That really might be what Governor Cuomo can do and Governor Deukmejian can do with a little encouragement.

Dr. WINN. I would like to make a couple of points.

Number 1, unfortunately the type of examination that has been suggested in the legislation would not in any way identify the person who is killing babies or dealing narcotics.

I am afraid that they are going to be able to go in and take that examination and pass it, because that is completely out of the loop.

I would like to relate to you one of the problems that we see about a minimum Federal standard——

Chairman STARK. If a guy were still out on bail, he wouldn't get relicensed, at least.

Dr. WINN. Well, one of problems is I think that the standard may get too low. The experience that we had with the FLEX examination was that the standard that was set throughout the Nation was a 75 to pass that examination for licensure.

New York said that that was too high, and they felt that too many physicians would not pass the examination. Therefore, they lowered in New York the standard to 70 in order to license a large group of physicians that would not be accepted for licensure in other States.

Over the period of time they would ratchet that up a little bit to 71, 72, and finally did adopt the 75 standard.

And if you want to look at a group of people out there to reevaluate, look at that group that got into New York under a substandard score.

So my feeling is that I am afraid that we are going to put another layer of protection on top of this unfit, unqualified physician. Because he is going to hold up that Federal standard and say, I don't care whether the PRO says I don't practice good medicine. I don't care whether the medical board says I don't practice good medicine. I passed the Federal examination.

Chairman STARK. I agree with you. I think that certainly can be the sole determination. If the three of you tell me that a guy can practice medicine, I will buy it; OK?

You ask whatever questions, you know the records you want.

You say I would like him to operate on me. I will say that is good enough for me. I will sign it.

I don't want some test that I could study for by buying the book at Crown Books and studying up like I can for the GRE and maybe even get a passing score. That isn't fair.

It has to be a combination of your experience and knowledge. But there seems to be a lot of differences in how they are both applied, what the penalties are, what happens to people who you three would agree are not currently competent or not competent without some further reeducation or training or help or whatever other qualifications you would require.

That doesn't seem to take them out of the loop temporarily. They are still able to apply their profession, and I am not sure that we would all agree that is right.

If you guys voted a physician down, what do we do next? That's where the system breaks down. I hope you will continue to work with us, and we would like to be of help.

Thank you very much.

Our next panel is comprised of physicians groups, and we are pleased to welcome Dr. Richard Popp, who is representing the American College of Cardiology.

Dr. Popp is also chairman of the American Board of Internal Medicine. It's a susceptibility board on cardiovascular disease. I will see you right after the hearing, Dr. Popp, with my various scores.

Dr. Graham, Robert Graham, the executive vice president of the American Academy of Family Physicians, and Dr. Harrison Visscher, representing the American College of Obstetricians and Gynecologists.

Gentlemen, welcome to the committee, and please proceed in any manner that you are comfortable with in the order that you appear on the witness list.

STATEMENT OF RICHARD L. POPP, M.D., TRUSTEE, AMERICAN COLLEGE OF CARDIOLOGY; CHAIRMAN, SUBSPECIALTY BOARD ON CARDIOVASCULAR DISEASE, AMERICAN BOARD OF INTERNAL MEDICINE (ABIM), AND MEMBER, ABIM TASK FORCE ON RECERTIFICATION; AND PROFESSOR OF MEDICINE AND ASSOCIATE CHAIRMAN, DEPARTMENT OF MEDICINE, STANFORD UNIVERSITY MEDICAL CENTER

Dr. POPP. Thank you, Mr. Chairman, members of the subcommittee, I am Richard L. Popp, M.D., associate chairman of the Department of Medicine at Stanford University.

I am also a chairman of the American Board of Internal Medicine Subspecialty Board on Cardiovascular Disease and a member of the ABIM Task Force on Recertification.

Chairman STARK. Doctor, even though this machine is turned on, you need to pull that microphone very close for anybody to hear you.

Thank you very much.

Dr. POPP. The college is a 18,000 member nonprofit professional medical society and teaching institution whose mission is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Thank you for allowing us the opportunity to comment on physician recertification, a concept supported by the college. We would also like to take this opportunity to provide some of our thoughts on H.R. 4464.

The American College of Cardiology (ACC) supports physician recertification. As reflected in our mission statement, we are dedicated to improving medical care through physician education and the generation of medical practice guidelines.

We share your commitment to quality for Medicare beneficiaries. We feel, however, that it is important to point out the mechanisms that are already in place and effective, and others that may be strengthened to accomplish our mutual goal of assuring quality of medical care.

Allow me, from the perspective of a professional medical specialty society, to describe some of our own activities in that area. The college provides extensive programs for continuing medical education and disseminates up-to-date knowledge in the field of cardiovascular specialty services.

An important educational experience for college members is our annual scientific session, which offers the opportunity for members as well as many others in the medical profession to attend symposia presenting information on state-of-the-art diagnostic and therapeutic practices, as well as core courses presenting clinically oriented reviews related to cardiovascular medicine and surgery. This year's meeting attracted more than 24,000 attendees.

The learning center, located at the college's headquarters in Bethesda, hosts more than 70 courses per year, serving more than 11,000 participants annually.

We are also experimenting with new educational delivery modes, including teleconferencing and video seminar offerings. All of these are in addition to the professional journal, educational tapes, and other regular publications of the college.

These are complementary to activities of the American Board of Internal Medicine and consistent with their conclusion that time-limited certification is the obligation of an accountable profession.

We also believe that ongoing scholarship is the key to better patient care. Periodic testing alone does not guarantee this goal.

Board certification recognizes a high level of professional achievement and not minimum competence. The proposed linkage of Medicare payment with recertification is a concept that deserves particularly close scrutiny.

H.R. 4464 proposes that the Department of Health and Human Services (HHS) Secretary develop a general competency exam for physicians; however, we believe that the construction of a valid and widely accepted competency exam is probably not feasible given the legitimate variations in the practice of medicine.

Development of tests of knowledge and judgment are difficult, complex and time-consuming if they are to be fair and professional-

ly credible. Further, competence is not the same thing as knowledge demonstrated on an examination, as you have already heard. Proper use of the knowledge a physician possesses is what we really want to assess.

The current certifying boards, with large, well-qualified staff and physicians in place, require at least 2 to 3 years to develop each of their examinations. That process also includes verification of clinical skills not tested by the written examination.

The bill would also allow the Secretary to approve the use of examinations of organizations already evaluating physician qualifications for licensure and certification. Since we believe the Secretary's efforts to develop a competency exam will likely fail, we are concerned that there will be pressure to make recertification the floor, or definition of minimal competency rather than of excellence.

The American College of Cardiology has been developing practice guidelines for a number of years. The college has joined with the American Heart Association (AHA) to form a Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures. Since its inception, seven sets of guidelines have been developed, and respondents stated explicitly that they believe such guidelines improve quality of care, decrease the need for defensive medicine, and serve as good educational tools.

Each guideline usually requires 18 months and five subcommittee meetings and costs approximately $50,000; however, direct costs are only part of the story. The real key to the development of outstanding practice guidelines is outstanding volunteer participation which runs between 400 to 600 hours per guideline. As a professional society, we are able to attract the most distinguished and notable scientists and professionals to give freely of their time.

We believe the Government should support the efforts of responsible professional organizations to fulfill the goal of improving the quality of medical care. The American College of Cardiology stands ready to work with you and to assure that Medicare beneficiaries receive the highest quality of cardiovascular specialty care. Through our efforts in the areas of professional education and practice guideline development, we believe that we are able to contribute significantly to this goal which we both share.

Chairman STARK. Thank you.

[The prepared statement and attachment of Dr. Popp follow:]

Statement of Richard L. Popp, M.D., F.A.C.C.
American College of Cardiology

Mr. Chairman, and members of the Subcommittee, I am Richard L. Popp, M.D., F.A.C.C., Professor of Medicine at Stanford University Medical Center, where I am Associate Chairman of the Department of Medicine. I am also the Chairman of the American Board of Internal Medicine (ABIM) Subspecialty Board on Cardiovascular Disease and a member of the ABIM Task Force on Recertification. I am here today representing the American College of Cardiology, where I serve as a Trustee.

The College is a 18,000 member non-profit professional medical society and teaching institution whose mission is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Thank you for allowing the College the opportunity to comment on physician recertification, a concept supported by the College. We would also like to take this opportunity to provide some of our thoughts on H.R. 4464, the Medicare Physician Qualification Act of 1990, requiring that physicians treating Medicare patients pass a periodic examination of their competence as a condition of payment.

The American College of Cardiology (ACC) supports physician recertification. As reflected in our mission statement, we are dedicated to improving medical care through physician education and the generation of medical practice guidelines. We share your commitment to quality for Medicare beneficiaries. We feel, however, that it is important to point out the mechanisms that are already in place and effective, and others that may be strengthened to accomplish our mutual goal of assuring quality of medical care.

Accreditation, Licensure, Certification and Recertification

As the Chairman knows, there are many steps along the road to establishing a medical practice that are intended to assure excellence in the preparation and performance of today's physicians. Entry qualifications to gain access to accredited medical schools, rigorous training programs, hospital credentialing, board certification, recertification, and certificates of special competence are all aimed at providing the stimulus for exceptional performance.

Allow me, from the perspective of a professional medical specialty society, to describe some of our own activities in that area. The College provides extensive programs for continuing medical education and disseminates up-to-date knowledge in the field of cardiovascular specialty services.

An important educational experience for College members is our Annual Scientific Session, which offers the opportunity for members as well as many others in the medical profession to attend symposia presenting information on state-of-the-art diagnostic and therapeutic practices, as well as core courses presenting clinically oriented reviews related to cardiovascular medicine and surgery. This year's meeting attracted more than 24,000 attendees.

The Learning Center, located at the College's headquarters in Bethesda, hosts more than 70 courses per year and we also sponsor approximately 35 extramural local courses yearly, serving more than 11,400 participants annually. We are also experimenting with new educational delivery modes, including teleconferencing and video seminar offerings. All of these are in addition to the professional journal, educational tapes, and other publications of the College.

Last year, the College established a Self Study Educational Materials Committee to develop new ways in which the College can provide members with materials to serve as useful learning aids for certification, recertification and the maintenance of up-to-date knowledge in a dynamic field.

The above are complimentary to activities of the American Board of Internal Medicine and consistent with their conclusion that time-limited certification is the obligation of an accountable profession. We also believe that ongoing scholarship is the key to better patient care.

Recertification--A Goal and Not a Floor

Board certification recognizes a high level of professional achievement and not minimum competence. The proposed linkage of Medicare payment with recertification is a concept that deserves particularly close scrutiny. H.R. 4464 proposes that the Department of Health and Human Services (HHS) Secretary develop a general competency exam for physicians; however, we believe that the construction of a valid and widely accepted competency exam is probably not feasible given the legitimate variation in the practice of medicine.

Development of tests of knowledge and judgement are difficult, complex and time-consuming if they are to be fair and professionally credible. Further, competence is not the same thing as knowledge demonstrated on an examination. Proper use of the knowledge a physician possesses is what we really want to assess. Manual skills and common sense are not easily tested with a written examination. Oral examinations are impractical both because of the number of physicians to be tested and because of the inconsistent results that occur when many examiners are involved. The sophistication and time required for reliable testing are enormous.

The current certifying Boards, with large, well-qualified staff and physicians in place, require at least two to three years to develop each of their examinations. That process also includes verification of clinical skills not tested by the written examination.

The bill would also allow the Secretary to approve the use of examinations of organizations already evaluating physician qualifications for licensure and certification. Since we believe the Secretary's efforts to develop a competency exam will likely fail, we are concerned that there will be pressure to make recertification the floor, or definition of minimal competency rather than excellence.

Federal Testing vs. Professionalism

Would federal testing enhance professionalism in medicine? The Institute of Medicine (IoM) recently conducted a two-year study of quality of care and the Medicare program. The purpose of the study was to design a strategy of evaluating and ensuring quality of care for Medicare beneficiaries. The panel of national experts called for a major overhaul of the current Medicare Peer Review Organization (PRO) program, citing the need to enhance professionalism and local involvement in quality assurance. I n other words, Mr. Chairman, this group of clinicians, academics, researchers, and policy analysts, believe that additional federal monitoring and oversight will not produce the intended results. The challenge is to develop incentives that will assist the profession in continuous quality improvement. Already, improvements in local credentialing procedures are underway and will be an important element of the whole process of assessing clinical competence.

Professional Practice Guidelines

The American College of Cardiology has been developing practice guidelines for a number of years. The College has joined with the American Heart Association (AHA) to form a Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures. Since its inception, seven sets of guidelines have been developed and widely disseminated. In 1985, a telephone poll was conducted that revealed 89 percent of the College's membership supports the

development of guidelines and stated explicitly that they believe such guidelines improve quality of care, decrease the need for defensive medicine, and serve as good educational tools. For your consideration, we have attached a list of the guidelines that have been or are currently being developed by ACC and AHA.

Each guideline usually requires 18 months and five subcommittee meetings and costs approximately $50,000; however, direct costs are only part of the story. The real key to the development of outstanding practice guidelines is outstanding volunteer participation which runs between 400 to 600 hours per guideline. As a professional society, we are able to attract the most distinguished and notable scientists and professionals to give freely of their time.

We believe the government should support the efforts of responsible professional organizations to fulfill the goal of improving the quality of medical care. The American College of Cardiology stands ready to work with you to assure that Medicare beneficiaries receive the highest quality of cardiovascular specialty care. Through our efforts in the areas of professional education and practice guideline development, we believe that we are able to contribute significantly to this goal which we both share.

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Harold T. Dodge, M.D., F.A.C.C.
J. Ward Kennedy, M.D., F.A.C.C.
Sylvan Lee Weinberg, M.D., F.A.C.C.

PUBLISHED REPORTS (in JACC and Circulation)

Guidelines for Clinical Intracardiac Electrophysiologic Studies (published 12/89)
Douglas P. Zipes, M.D., F.A.C.C., Chairman

Guidelines for Ambulatory Electrocardiography (published 1/89)
Suzanne B. Knoebel, M.D., F.A.C.C., Chairman

Guidelines for Percutaneous Transluminal Coronary Angioplasty (published 8/88)
Thomas J. Ryan, M.D., F.A.C.C., Chairman

Guidelines for Coronary Angiography (published 10/87)
John Ross, Jr., M.D., F.A.C.C., Chairman

Guidelines for Clinical Use of Cardiac Radionuclide Imaging (published 12/86)
Robert A. O'Rourke, M.D., F.A.C.C., Chairman

Guidelines for Exercise Testing (published 9/86)
Robert C. Schlant, M.D., F.A.C.C., Chairman

Guidelines for Permanent Cardiac Pacemaker Implantation (published 5/84)
Robert L. Frye, M.D., F.A.C.C., Chairman -- (currently being revised)

FUTURE REPORTS

Guidelines for the Early Management of Patients with Acute Myocardial Infarction
Rolf M. Gunnar, M.D., F.A.C.C., Chairman

Guidelines for the Clinical Application of Echocardiography
Gordon A. Ewy, M.D., F.A.C.C., Chairman

Guidelines and Indications for Coronary Artery Bypass Graft Surgery
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(January 1990)

Chairman STARK. Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. GRAHAM. Thank you, Mr. Chairman.

I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians, some 68,000 members. We appreciate very much having the opportunity to present our comments before you this afternoon.

The experience of family practice is perhaps useful and instructive for the committee. Since its inception in 1970, all board certification in family practice has been time limited.

Now, the academy is not the certifying agency in family practice. That is the American Board of Family Practice. But since 1970, every diplomate in family practice has received a time-limited certificate of 7 years, which must be renewed by written examination and review of practice records on either the 6th or 7th year.

The experience is, although such recertification is voluntary, almost without exception, current certificate holders do subject themselves to reexamination.

We understand and to some extent share the concern of the committee as expressed in the bill of ensuring that there is quality assurance for Medicare beneficiaries in their encounters with the physician population.

We note and would support the suggestion in the bill that the PPRC be charged with further investigating the relationship with malpractice claims experience, certification, and physician quality.

Partially because from data available to us, and I believe also available to the committee, from the GAO, there is a strong suggestion is that at the present time, there is no current direct relationship between board certification and malpractice suit experience.

Indeed, if anything, there is the suggestion that those holders of board certificates may be more likely to suffer malpractice claims.

That, to us, is probably explicable in terms of complexity of cases seen and does not suggest a lower quality of care. But at the same time, it calls into question the basic premise on which the bill appears to be based.

We would further express several concerns with the proposed structure of the bill. In particular, the concept of a general medical exam.

As several of the witnesses previously have expressed, we have concerns whether or not a single national paper and pencil examination is adequate to assure any minimal level of competency is open to challenge.

And of greater concern, I believe, is the suggestion that we might promulgate upon both the profession and the public an exam which would suddenly come to be seen as a loophole rather than any level of excellence.

At the present time, every individual who chooses to sit for board certification must complete a residency, must have been peer reviewed to the extent that they are found to be competent to practice by the director of that residency.

No such requirement would be made as it appears for the sex examination. One could well imagine that the outcome of a Secretary's examination would be suddenly the avenue towards some sort of Federal standing which did not require residency training, which did not require any rigor or preparation which is presently the case for American physicians, and indeed would be perceived as an easy out and an assured access to a Medicare population.

We believe that this is not the intent of the committee, nor desirable public policy. We also share the concerns that have been expressed earlier about the potential implications of access for services on the part of the Medicare beneficiaries should some of the provisions in the bill in fact become law.

At the present time because of the structure of board certification outside of family practice, there are a large number of legitimate specialists who either do not hold time-limited certificates or who are themselves not board certified.

These individuals suddenly have a new hurdle placed in front of them do somehow become credentialed in the eyes of the Secretary to become a Medicare participating or providing physician.

It's almost inescapable to assume that large numbers of those individuals who choose not to subject themselves to this additional certification criteria would remove themselves from access to the Medicare population.

We believe again that this is probably not the desire of the committee, nor desirable public policy outcome.

In summary, we do support the interests of the committee in assuring that there is quality medical care for Medicare beneficiaries and believe, given the premise in the bill that there is a link between malpractice experience and certification, that this premise should be thoroughly studied and analyzed by the PPRC.

We suspect that the final outcome of good public policy will be the working relationship that the chairman has already suggested with existing certifying agencies and State medical boards of licensure and continued work on the part of this committee and others in examination of reasonable approaches to tort reform.

Thank you very much, Mr. Chairman.

Chairman STARK. Thank you, Dr. Graham.

[The statement of Dr. Robert Graham follows:]

Statement of Robert Graham, M.D., Executive Vice President
American Academy of Family Physicians

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians. I appreciate the opportunity to discuss with the Subcommittee on Health the Academy's views on the Medicare Physician Qualification Act of 1990. This legislation would require physicians to pass a qualified recertification examination at seven year intervals or be licensed in a state with a federally-approved, time-limited licensure program in order to receive payment for services provided under the Medicare program.

Support for PPRC Study:

I would begin by commending you, Mr. Chairman, for your continuing concern that Medicare beneficiaries receive services from well qualified physicians. The Academy shares your commitment to quality medical care, and believes that this should be achieved in a manner which builds on the current methodologies of assessing physician competence. For this reason we support the provision of H.R. 4464 which calls for the Physician Payment Review Commission (PPRC) to study the current methods and submit a report to Congress with recommendations regarding the types of evaluations that should be used and the characteristics of organizations that should conduct such evaluations. We would further suggest that such a study explore whether an additional "structural" requirement will result in improved quality of care. Of all the indicators of quality, using the structure-process-outcome paradigm, structure appears to be the least closely related to quality.[1] The PPRC has an excellent record of providing thorough analysis of seemingly formidable issues and developing practical and politically feasible recommendations. We believe that Congress, beneficiaries and physicians would be well served by pursuing this particular issue with PPRC, and the Academy would welcome the opportunity to work with you and the Commission.

Concerns relating to Access:

However, in the absence of a study recommending that a totally separate system of certification of practitioners be set in motion, we have serious concerns about the approach proposed in the legislation. This could be potentially disruptive of the present system of certification, provide an opportunity for less competent physicians to become federally certified and cause serious problems regarding access to care by beneficiaries.

The strategy may well result in a dramatic curtailment in access to Medicare providers. Currently, only the American Board of Family Practice has a time-limited examination which requires recertification of all diplomates every seven years. Approximately 72 percent of the Academy's active members are currently so certified. With the requirements of the legislation, only these physicians would have the potential to qualify for Medicare reimbursement through their own specialty board certification. Other specialties are considering or have decided to implemented time-limited certification.

However, internal medicine, for example, will "grandfather" those individuals currently certified, so that only physicians newly certified after 1991 will be required to be recertified. Under the proposed bill, the thousands of internists now certified and caring for Medicare patients would be required to either take the proposed general practice examination offered by the Secretary of HHS, or be relicensed periodically by the state. This would be the case for all other specialists who currently are certified by a board that is not time limited for seven years. Also of

concern are those family physicians not certified and who, because of the requirement of completion of a family practice residency program, are ineligible to take the examination for certification by the American Board of Family Practice.

Given the present Medicare requirements, many of which are perceived by physicians to be unnecessarily burdensome, we would anticipate that many of these physicians would object strenuously to a requirement that they pass a federally-administered examination, and simply decline to accept Medicare patients. Additionally, because the legislation would require substantial modification of the present system of board certification for many specialties, it would seem prudent to first study the system and determine how best to accomplish quality assurance through certification.

Requirements for certification/recertification in Family Practice:

A review of the requirements for board certification in family practice may be helpful for the Subcommittee. All candidates for the American Board of Family Practice Certification Examination must have satisfactorily completed three years of training in a family practice residency program accredited by the Accreditation Council for Graduate Medical Education subsequent to receipt of the M.D. or D.O. degree, and hold a currently valid, full, and unrestricted license to practice medicine in the United States or Canada.

The examination is a one day written test of cognitive knowledge and problem solving abilities relevant to family practice. Elements of the examination include but are not limited to diagnosis, management, and prevention of illness. All diplomates of the American Board of Family Practice are routinely requested to participate in the recertification process every six years, although certificates are dated for seven years, to allow time for the examination to be taken prior to the expiration of the certificate. The recertification process consists of four major elements: 1. continuing medical education; 2. licensure; 3. office-record review; and 4. cognitive examination. The American Board of Family Practice was the first medical specialty board to require periodic recertification and has been recertifying Diplomates annually since 1976.[1]

The Federal "General Practice" Examination:

The Academy has a particular concern with the creation of a federally-administered "general practice" examination and the impact on the quality of Medicare providers. This route to "certification" to care for Medicare patients appears to offer an approach which likely will be less demanding than the current certification process and which may well generate a cadre of physicians with less evidence of competence. For example, a family physician must have successfully completed a three year family practice residency training program in order to qualify to take the examination offered by the American Board of Family Practice. Presumably, a physician who completes one year of internship and obtains a state license would be able to take the federal "general practice" examination and receive federal certification. For those physicians unwilling or unable to withstand the rigors of a multi-year residency program, this pathway would provide easy access to the Medicare program, while doing nothing to improve or assure the competency of physicians caring for the elderly and disabled.

Role of the Medicare Program:

In addition to the above noted concerns which address the specific approaches outlined in the legislation, we have a more fundamental concern which relates to the whether this is an appropriate role for the Medicare program. The Medicare program has several mechanisms to disqualify

providers from participation, and an extensive program of carrier and Peer Review Organization review for determining that services provided meet the program requirements for appropriateness and quality. Traditionally, medical licensure has been under the purview of states, and certification accomplished voluntarily in the private sector. We question whether federal mandates regarding licensure and certification requirements are appropriate and reiterate support for a study by the PPRC regarding approaches to ensuring continuing competency of providers, and by whom such strategies should be implemented.

Impact on Medical Malpractice:

Remarks by the Chairman regarding the legislation which are contained in the Congressional Record note, "The need for this action is demonstrated by high rates of medical injuries and the burden that malpractice places on the health care system." Data do not appear to validate this assumption that mandatory, periodic certification and recertification will reduce the incidence of medical liability suits. The 1987 GAO report entitled Characteristics of Claims Closed in 1984 reports a study of over 71,000 malpractice claims. The GAO study found that of 71,930 claims, a majority (36,495) were filed against board certified physicians and 10,537 were filed against physicians who were not board certified. In the remainder of claims (24,898), board certification status was unknown. In other words, of the 47,032 claims filed against physicians whose board certification status was known, 78 percent of claims were filed against physicians who were board certified.[1] It is clear that the fact a physician is board certified does presently not make it more unlikely that he or she will be sued. If it is the Chairman's contention that board certification will weed out those physicians most likely to be sued, we do not believe that the facts support this. The bill's requirements therefore are not apt to reduce the number of medical malpractice claims filed.

Summary:

The American Academy of Family Physicians shares the goal of the Chairman of ensuring that Medicare beneficiaries receive quality care from well qualified physicians. However, we believe that various options for ensuring continuing competence of providers should be studied prior to the imposition of federal requirements that potentially could disrupt the current systems of certification and licensure and result in a serious crisis of access to physicians. The Physician Payment Review Commission would be an appropriate resource to the Congress in this regard, and the Academy supports provisions of H.R. 4464 calling for such a study. In addition, the specialty of family practice is committed to continuing competence and the assurance of quality of physicians practicing medicine. The Academy would welcome the opportunity to work with the Physician Payment Review Commission and this Subcommittee to explore strategies for achieving our mutual goals.

Thank you very much for the opportunity to share with you the thoughts of the American Academy of Family Physicians.

Chairman STARK. Dr. Visscher.

STATEMENT OF HARRISON C. VISSCHER, M.D., DIRECTOR OF EDUCATION, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. VISSCHER. I am Dr. Visscher, director of education at the American College of Obstetricians and Gynecologists.

One of our most important missions is to assist our physicians in their continuing professional development, thus enabling them to maintain a high level of clinical competence.

The expansion of medical knowledge is so rapid that it has become impossible for physicians to remain competent unless they continue their education as long as they practice. To this end, ACOG strongly supports the periodic assessment of physician competence though recertification.

Since clinical competence involves many factors, as you have heard, such as cognitive knowledge, technical skills, and a commitment to patient care, it proves difficult to measure. The written examination alone cannot adequately test the clinical competence.

Specialty specific examinations and a review of a physician's actual practice provide better measures. This is the method used for recertification of the obstetrician/gynecologist.

An even better method in my opinion is appropriately designed and conducted quality assurance type of peer review of medical care. Board certification and recertification in our specialty are both voluntary.

Certificates issued prior to 1986 are valid indefinitely. Those issued after 1986 are valid only for 10 years.

It's important to note that physicians who are not board certified may practice obstetrics and gynecology. This is also true of those who do not pass a recertification examination.

To be recertified as an obstetrician/gynecologist, a physician must pass a 150 question written examination; and in addition, they must submit to a review of their hospitalized patients for a recent 6-month period.

To help physicians in assessing their clinical competence and preparing for recertification, ACOG initiated two programs. The first one is PROLOG, or Personal Review of Learning in Obstetrics and Gynecology. PROLOG is a voluntary educational self-assessment program covering the major practice areas within our specialty.

Thirty-five percent of our members participated in the first 5-year cycle in this program alone. At 4-year intervals, we also published PRECIS, an update of what is new and current in our specialty.

These two publications are the content basis for our certification and recertification examinations. Attached to our written testimony is a list of many other educational programs that ACOG offers to help its fellows.

There has been much discussion recently about the mandatory recredentialing effort in New York. Recredentialing differs from recertification in that it applies to all physicians, not just those who are board certified.

New York would require all physicians to be recredentialed every 9 years. They emphasize it's educational and nonpunitive, as you heard this afternoon. ACOG is eager to help them in their recredentialing process by making our education processes and practice guidelines available for their use.

As you also heard Dr. Gellhorn say, ACOG is cooperating with the New York Department of Health in a unique pilot project by reviewing the quality of obstetric care in 24 hospitals focusing on Cesarean delivery rates. Initial experience indicates that programs of this nature could be useful in recredentialing physicians.

In closing, ACOG would like to commend the subcommittee and particularly you, Mr. Chairman, for holding this important hearing. We are encouraged by your interest in the need to evaluate physician competence in the form of recredentialing, recertification or self-assessment.

The key issue in efforts to assure physician excellence and high quality health care is continuing medical education.

We recognize that as the practice of medicine becomes more complex, continuous assessment of knowledge, skills and clinical behavior is necessary to insure the delivery high quality of medical care that the public deserves.

Thank you.

Chairman STARK. Thank you.

[The statement and attachment of Dr. Visscher follow:]

Statement of Harrison C. Visscher, M.D.
The American College of Obstetricians and Gynecologists

Mr. Chairman, Members of the Committee, I am Harrison Visscher, MD, an obstetrician-gynecologist. I have served as director of a residency program and chairman of an OB/GYN department. I am presently Director of the Education Division of the American College of Obstetricians and Gynecologists (ACOG). I am delighted to be here today testifying on behalf of ACOG, which represents more than 29,000 physicians specializing in the delivery of health care to women, on the issues of periodic assessment of physician competence, which includes recertification.

ACOG strongly supports the concept of periodic assessment of physician competence, whether it be in the form of self assessment, recredentialing, or recertification. One of our most important missions is to assist obstetrician-gynecologists in their continuing professional development, enabling them to maintain a high level of clinical competence. We commend Chairman Stark and Members of the Subcommittee for acknowledging that there is a vital need for periodic assessment within the medical profession.

The expansion of medical knowledge in recent years has been so rapid that it has become impossible for physicians to remain highly competent unless medical education continues as long as they practice. The public expects physicians to remain clinically competent.

Once the physician has completed an accredited graduate medical education program in obstetrics and gynecology and attained initial certification as a specialist, ACOG has a responsibility to the public to promote continuing clinical competence of its Fellows. Clinical competence includes the following components: cognitive knowledge, technical skills, interpersonal skills, moral and ethical behavior, and a commitment to patient care.

The validity of various mechanisms for evaluating clinical competence varies considerably. Documented attendance at continuing medical education meetings alone is an invalid measure of competence. Written examinations by themselves are an improvement, but leave much to be desired. This is especially true if it is a broad based written exam, covering all of general medicine. Most physicians limit their practice because it is impossible to maintain competence in all areas. And in our view, physicians should be evaluated only in those areas in which they practice. Specialty specific written exams plus a review of a physician's actual practice cases provide somewhat better measures. Presently, this method is used for recertification of obstetrician-gynecologists. A quality assurance type of peer review of the outcome of care in the medical institutional setting is potentially an even better measure. This may be the best way for simultaneously evaluating cognitive knowledge, technical skills, and professional conduct. Moreover, it may be the most appropriate way to establish continuing medical education needs and ultimately to serve as the basis for the granting of hospital privileges.

It is important to note that a focus on outcome of care must take into account the health care resources of the community, and compliance of the patient, as well as physician competence. Community resources include hospital facilities and professional staffing, available technology, and the funding available for health care services. Patient compliance with medical advice is affected by lifestyle, including such factors as smoking, use of drugs and alcohol, sexual habits, occupational environment, and nutrition. For example, lifestyle is an important determinant of a good obstetric outcome.

PAST HISTORY

In 1951, ACOG was created to promote the high quality delivery of health care to women. From the outset, a major focus of our activities has been continuing education of our physicians. For your information, we have attached a list of ACOG's current educational programs and publications. ACOG's role in periodic physician assessment is to define the curriculum, develop and provide educational programs and activities, and produce a voluntary self assessment program for obstetrics and gynecology.

In 1963, ACOG made board certification a requirement for membership. The American Board of Obstetrics and Gynecology (ABOG), which was established in 1930, tests the qualifications of candidates on a voluntary basis for certification and recertification by testing their ability to demonstrate special knowledge and professional competence relating to obstetrics and gynecology. Certification is a two-part process. The first part requires

passing a written examination after graduating from an approved residency training program. After a physician has practiced the specialty for 2 years, he or she must pass an oral examination focusing on the physician's actual practice activities.

In 1973, ABOG endorsed recertification and a Liaison Committee on Recertification was developed between ABOG and ACOG. In 1978, recertification was granted to obstetrician-gynecologists for the first time. Currently one-third of eligible board certified obstetrician-gynecologists have been recertified.

To assist physicians in assessing their clinical competence and in preparing for recertification, ACOG initiated a program called PROLOG (Personal Review of Learning in Obstetrics and Gynecology). This program is a voluntary, confidential educational program consisting of 5 modules. It is a complete curriculum covering obstetrics and gynecology. The modules cover obstetrics, gynecology, reproductive endocrinology and infertility, general gynecologic oncology, and patient management in the office. Almost 10,000 ACOG Fellows, about 35%, participated in the first cycle, which was completed in 1987. In addition to PROLOG, the College has also produced an interactive computer software self-assessment program called INTERACTIONS.

RECERTIFICATION

The purpose of recertification is to provide objective evidence, through a process periodic evaluation, that a specialist has maintained continuing qualifications at a currently acceptable level. Recertification is voluntary, as is original certification. Recertification evaluates the knowledge base, clinical judgment, and special skills of the individual obstetrician-gynecologist. A significant aspect of the process is education.

Certificates issued to obstetrician-gynecologists prior to 1986 were valid indefinitely. Certificates issued on or after 1986 are valid for only ten years. It is important to note that physicians who are not recertified, just as those who are not initially certified, may continue to practice the specialty. Both ACOG and ABOG have already begun to lay the foundation for recertifying the physicians whose certificates are time limited.

Current plans for recertification, for those physicians wanting to maintain their board certification status involves development of a 150-question written examination of which 100 questions will pertain to the general practice of obstetrics and gynecology with the remaining 50 questions based on the physician's choice of practice area. The latter 50 questions concentrate on one of the following areas: general obstetrics, general gynecology, reproductive endocrinology and infertility, gynecologic oncology, or ambulatory care. In addition to the written exam, those physicians seeking recertification will undergo a review of their practice activities. This portion of the process will require a review of data derived from the medical records of patients under the physician's care who have been discharged from the hospital during a recent 6-month period. To facilitate this effort, ACOG has developed a computer software package to assist the physician in maintaining the proper information on each patient. This software is available free to any ACOG Fellow.

There are a number of specific requirements an obstetrician-gynecologist must meet for recertification:

1) The physician must be certified or recertified by the Board six or more years prior to July 1st of the year in which application is made for recertification.

2) The physician must have an unrestricted license to practice medicine in one of the states or territories of the United Stated or a Province of Canada.

3) The physician must be of good moral and ethical character.

4) The physician must be actively engaged in unsupervised hospital patient care for no less than 12 months prior to date of application.

a. Independent unsupervised hospital patient care for no less than 12

b. Unrestricted privileges to practice as an obstetrician-gynecologist in each of the hospital(s) in which the physician has been responsible for patient care for the 12 months prior to date of application.

5) The physician must be able to provide a list of all patients dismissed from care in all hospitals for a 6-month period.

RECREDENTIALING

Throughout the United States, about one-q arter of physicians practicing obstetrics and gynecology are not specialty board-certified. For example, in New York, which contains 10% of U.S. physicians, 27% of physicians practicing obstetrics and gynecology have never been certified. Therefore recertification is not an option for them.

There has been much discussion recently about the mandatory recredentialing effort in New York. This effort would require all physicians, certified or not, to be recredentialed as a condition of continuing in practice. In addition to requiring a physician to periodically renew his or her state license, the New York proposal would require physicians to be recredentialed every nine years. A physician would have the option of selecting one of three methods for recredentialing:

1) By being certified or recertified by one of the approved specialty boards

2) By passing a cognitive examination based on clinical problem-solving

3) By satisfactory participation in a peer review of clinical practice records

A great deal of concern has been voiced about using a written general medical examination as the sole criteria for recredentialing. It does not evaluate technical skills or attitude. It is too general and only tests a physician's cognitive knowledge. New York's Recredentialing Advisory Committee, formed in 1987, has recommended that the process of recredentialing should be educational -- not punitive -- and further, that failure to recredential should not result in the loss of the license to practice medicine.

ACOG has offered to assist in the New York recredentialing process with a willingness to make available our educational documents and practice guidelines featuring background information for use in the development of recredentialing test programs.

Our New York ACOG Fellows are also piloting a hospital obstetric review program focusing on cesarean delivery rates in conjunction with the New York Department of Health. They are reviewing 24 hospital obstetric departments during the first year. Initial experience indicates that programs of this nature could be useful in recredentialing physicians.

Conclusion

ACOG would like to commend the Subcommittee, and particularly its Chairman, for holding this important hearing. We are encouraged by the interest shown regarding the continuous need to evaluate physician competence in the form of self assessment, recertification or recredentialing. It is also essential to understand the role that continuing medical education has to play in this process.

As the practice of medicine becomes increasingly more complex, continuous assessment of knowledge, skills, and clinical behavior is necessary to deliver the high quality of medical care the public expects.

ACOG EDUCATION PROGRAMS

In addition to outlining the curriculum for obstetrician-gynecologists and producing the two self-assessment programs, **PROLOG** and **INTERACTIONS**, we publish educational materials and conduct a number of educational activities including:

- **PRECIS.** Published every four to five years, PRECIS serves as an overview of the specialty with a focus on the latest advances in clinical practice. The next version will be available this June.

- **TECHNICAL BULLETINS AND COMMITTEE OPINIONS.** ACOG periodically develops Technical Bulletins and Committee Opinions, both of which are designed to provide the physician with up-to-date practice information.

- **FREE STANDING POSTGRADUATE COURSES.** ACOG conducts post-graduate courses designed to ensure that the physicians' learning process meets their clinical needs.

- **ANNUAL CLINICAL MEETING.** Each year, ACOG's Annual Clinical Meeting allows physicians an extensive arena for further education.

- **ACOG AUDIO VISUALS.** ACOG offers a number of audio cassette and video information updates and digests as well as a series of slide/audio-tape self learning packages.

- **ACOGNET.** ACOG has established ACOGNET, which provides Fellows with computer linkage to all College publications and membership news.

- **ACOG RESOURCE CENTER.** We responded to approximately 100,000 information requests in 1989, with 50% originating from health professionals and 50% from the public.

PRACTICE STANDARDS AND GUIDELINES

ACOG also establishes standards and guidelines for practice. A number of publications result from these efforts.

- **ACOG STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES.** This book provides information on the organization of ambulatory and hospital settings as well as the care of the patient in these settings.

- **GUIDELINES FOR PERINATAL CARE.** This is a uniquely coordinated, multidisciplinary approach between ACOG and the American Academy of Pediatrics, resulting in a book which describes national guidelines for perinatal risk assessment and regional planning.

- **QUALITY ASSURANCE IN OBSTETRICS AND GYNECOLOGY.** This publication prescribes a formal approach to the critical examination of obstetric and gynecologic clinical care processes and patient outcomes through the use of two tools: clinical indicators and criteria sets.

Chairman STARK. Mr. Coyne.

Mr. COYNE. No, sir.

Chairman STARK. Let me just yield for a second with the access thing. There are several witnesses this afternoon who have suggested that. First of all, I don't believe it. If a person has a fairly large practice with Medicare now, I don't figure they are going to walk away from that, and it tends to vary with specialties.

Whereas an ophthalmologist is going to gross $6 million, if he's not grinding through an awful lot of laser cataract surgery—so if that guy in Detroit doesn't want to be recertified, I don't think Medicare would miss him.

If we in fact took what the family physicians do, we would have 75 percent of them who wouldn't qualify, isn't that correct, 75 percent of the family physicians ?

Dr. GRAHAM. In the AMA master file, there are some 62,000 physicians who identify themselves of general or family physicians of whom only 25,000 are holders of certificates from the American Board of Family Practice.

You would have over 40,000 family and general physicians today who are outside of that certification process. Certification for family practice has only been available since 1970.

Chairman STARK. You are saying there are 75 percent who call themselves family practitioners?

Dr. GRAHAM. Yes. That is one of the reasons that we point to——

Chairman STARK. How about the internists—who knows?

Dr. POPP. It's about 75 percent of the internists; 40 are certified.

Chairman STARK. Who are certified, OK.

I will bet those 75 percent, 40 percent of whom are certified, have enough room in their appointment books to pick up the slack from the 25 percent who decided they didn't want any Medicare patients.

Dr. POPP. I think you may be right, sir, but again, I think, as someone suggested, we ought to study that I am concerned that because of the way medical practice works, there is a possibility that there may be a disproportionate number of uncertified physicians, for example, taking care of their patients in the inner city.

And I think until we know the statistics on that, it will be very hard to predict what the effect would be.

Chairman STARK. That's a good point. About 250,000 out of roughly 400,000 are certified by the corresponding board only. So I was off; it was 75 percent of the internists and not family practitioners.

I will just say I have never been that concerned that this would happen. Isn't it fair for a layman to assume, if I were going to send my wife or my daughter to an OB/GYN, wouldn't I be making a good consumer-choice by saying I ought to pick one who is board certified?

Dr. VISSCHER. Yes, I believe there is evidence for that.

Chairman STARK. So if I am leading this committee, if Mr. Coyne will allow me the first person as a prerogative of the Chair, isn't there some way we could do it at no additional expense that it wouldn't be a bad idea to try and figure out a way that the Medicare system could provide our beneficiaries with the services of board certified physicians?

The odds are we would be getting better skilled service, right?

Dr. POPP. Well, if I might respond to that, sir.

I think that you and I would both agree that the boards are trying to certify a higher level of performance and knowledge, et cetera. But it doesn't mean that the people who are not certified are providing very poor or substandard care.

Chairman STARK. I agree completely, but there is absolutely no way in God's world that Mr. Coyne and I could figure that out.

Most of the time I cannot spell the specialty, much less know what it does. I think you have all testified that as a layperson who wants the assurance that I am getting in the community the cream of the crop, I would have a lot better odds of finding somebody if they were board certified.

Is that fair?

Dr. POPP. I think that is fair, but the question is whether we should or whether we should not essentially disenfranchise the people that are competent but not at a high level.

Chairman STARK. OK.

Now, next issue, separate issue, disenfranchise; I think that is what we are missing here to a great deal.

I have no quarrel with suggesting that if somebody doesn't join your club, they ought to be out. I will give you a great example.

Access. In my community, half of the people who have insurance belong to Kaiser. When I moved into that county, none of the medical societies would let any physicians who practiced in Kaiser join, because they were prima facia unethical.

It was unethical as an edict of the AMA, and it's affiliate groups, to practice on an HMO for a salary.

Now, times have changed, and I guess the AMA recognizes the HMO today. But those guys may never have been certified because they couldn't join the club.

Interestingly enough, they practice with about half the number of physicians per thousand than the rest of the county is provided.

The county is interesting in that half of the people belong to Kaiser, and the other half are in the fee-for-service market, of those who are at an income level to have any kind of medical care; and the other couple hundred thousand receive care at the local hospital .

On that, it's an interesting case study, but I am just suggesting that that doesn't mean I don't think that Kaiser doesn't have perfectly competent physicians, and many of them now are certified because of the younger guys who come into the system.

So I guess I don't think that that is necessarily a mark of quality. But at the other end of the square are the incompetents, the people who play the procedural part of the system.

Let's assume that we could all agree with Dr. Graham's tests here that that is the way it ought to be, continuing education, licensure, office record review, cognitive exam, a good general study of a person's ability to practice.

Now, at the other end of that scale, there are people who ought to be excluded. Those same people that I think this panel, as I challenged the other, would absolutely agree, a guy's a drug addict, a person never went to medical school, he's one of these flimflam art-

ists that con us into thinking they are doctors when they are really not.

Even they play the game in the system. They keep a license while they force people into appeals, and I am just suggesting that at that end of the system as well, there ought to be a way to quickly move them out.

I guess it's coming back to the idea of peer review. Why shouldn't a person have to be reviewed periodically in some form or another and recertify?

You do it, Dr. Graham, with family practitioners. Is it voluntary or not for them to recertify?

Dr. GRAHAM. For individuals who are board eligible, it's voluntary. Almost everyone does it.

If I might comment on your introduction to the question, though, I believe that is where I see a conflict in the examples and the suggested remedy in the bill.

Those worst case horror stories that you select have to do with adjudication and administrative process. They have nothing to do with credentialing.

As a matter of fact, I would not be surprised but what those two physicians that you cited during the prior panel with apparently egregious professional misconduct may well have been board certified.

We have, you know, somewhat tongue-in-cheek talked about the problems of the airline industry. I know no single industry where the certificants, the pilots, are more stringently watched.

Those pilots have check rides from the FAA every month. They have quarterly simulators. They go through all types of things that a physician or any other professional does not go through, and they still have problems.

And I think I see a confusion there between what should happen when there is an identified misbehavior on the part of an individual, no matter how credentialed, and possibly using some level of credentialing to assure that will never happen.

I think we have every reason to believe unfortunately that no matter how good nor how narrow your credentialing process, that is, the FAA, you will still have occasional misbehavior.

The concern that we have in a major way with the provision in your bill of creation of a Secretary's exam is it would appear to be an enormous loophole, encouraging individuals as a matter of fact to forego specialty training and certification, to take a lowest common denominator examination, and say here, I have a sheet of paper from the Secretary of HHS. I don't need to listen to my State licensure board. I don't need to listen to my certification board.

I think you have got two different things to address. One is adjudication. The other is credentialing.

Chairman STARK. I agree with that, but even in credentialing, the only honorary degree I have is a GED. That is the lowest common denominator of academic degrees.

Now, I would not wear the mantle in the processional in which I was to give the graduation address, because it's a relatively shabby mantle compared to all the others that worked a lot harder than I did for my honorary GED.

Nonetheless, it's understandable, that's the degree itself. So that if we said, for example, let the EBS—is that what they are called?

Dr. VISSCHER. ABMS, the American Board of Medical Specialist.

Chairman STARK. ABMS certify, but for those who don't do it, let the Secretary's degree be arguably the less desirable.

Dr. GRAHAM. It's an enormous loophole, sir. It's an incentive to do less rather than to do more.

Chairman STARK. Well, there is that same thing now. If they don't get an ABMS certification, they still have a State license.

Dr. GRAHAM. Absolutely.

Chairman STARK. And——

Dr. GRAHAM. Which this would appear to supplant.

Chairman STARK. I am not sure. It would seem to me that it could be a minimum standard for State licensing to say that the State has to do the recertification or relicensing, whatever you want to call it, periodically, fine, and let the States laws be tougher, fine.

But I think there are some States that do not do as good a job as other States. I think we all agree that some States are more stringent and some States pay more attention to it than others, and some do less.

So pick the median, and let's set that as a Federal standard for States to do it. You deal with the people who want to put in the extra effort voluntarily and get you to cooperate with us by getting out of the ABMS to make it periodic.

And then why don't we have the best of both systems?

Dr. VISSCHER. If I may——

Dr. POPP. Excuse me. I just want to make a point that I think what the Chairman is trying to do is develop also an effective system.

It seems to me the most effective way to deal with the physician who is impaired, the physician who does bad things, even though he knows he shouldn't do bad things, is at the local level.

An association like the American College of Cardiology disseminates practice guidelines. Those can be adopted by the local hospital. The credentials committees are now getting much more serious about looking at people on a year-by-year basis, let alone several years at a time.

And if someone is found, for example, to be drunk before he goes into surgery, it's at the local level that you would identify that and do something about it right away.

So I would encourage the committee to think about a way that we could work with organizations, such as those that you see here, to work out a method to support and provide incentives for making those local assessments or peer reviews more rigid, more realistic, and more peer review that is meaningful.

Chairman STARK. OK.

Let me ask each of you, Dr. Visscher, you wanted to add something. But before you do, as I talked with the other panel, it seems to me there are one of two choices. In the peer review situation as it exists now, they have to affirmatively go after a physician to censure, punish, or defrock him or her, right? That is the way the system works now.

Peer review guys have to go out and say, we have discovered something that is wrong with you, and now we are going to go after you, and you can either do it that way or you can do it on the flip side, if there was some kind of periodic recertification, relicensure, which makes it the physician who has to come to the peer review group and ask for their blessing.

And I don't know that there is any in-between, particularly , if you had reason. Which would you take? Isn't it better for the profession and the review group to have it basically the physician who has to come forth and show that he or she should be relicensed?

Dr. POPP. But there is a kind of middle ground between the two, and that is that at the local level in the hospital, there is the review of the physician on a year-by-year basis. But he also has to provide all of his material to be credentialed in that hospital.

Chairman STARK. I have had about 18 cases from around the country of doctors complaining that they are being done in because they wouldn't join in a joint venture. You cannot own something you are referred to, and they are being kicked off the hospital staff because of the guy that is jealous.

I really sense that you can get too local and either get into a lot of locker room politics or get into something where nobody is censured because it's a go along-get along sort of thing.

If you said State level or, if it isn't like each little community, I would be more comfortable. But that is just an observation.

Dr. POPP. Well, if I have to pick one, I think I would probably pick the PRO model. The question is, can it be done in a way that is really effective?

And I think that is what you would want. That is what I would want, to build something that is effective. And I am a little concerned that we would build too big an edifice to catch some people that we want to catch and make sure that the powers that are going to catch that person are right.

Dr. VISSCHER. I see the theoretical attractiveness of what you are suggesting. However, based on our experience in screening members for membership in the American College of Obstetricians and Gynecologists, we try to do a lot of things that I think you are suggesting. But we still have some bad apples.

And what I guess that says is that we do not have the mechanisms to give the assurances you are suggesting we might be able to give.

Therefore, we find a better criteria is to review what physicians do at the local level. We have developed guidelines to assist in this effort.

That is why we are conducting this pilot project in New York where I feel confident we are going to show a positive impact on the cesarean rates. This will allow us to follow up on our initial criteria of evaluating a physician.

If we could to a better job initially, you might be right. But I guess we have to admit that people get through the loophole. Many agree that a written examination will not screen out the criminal or the drug abuser.

Therefore, I believe it has to be a combination, and I believe, also, that the focus should be, as New York is trying to do, to focus

on education and be nonpunitive initially to give opportunity for remediation if it's identified.

And that is one thing we have lost track of here or haven't mentioned. There are different types of evaluations.

For instance, even with written evaluations, if you are talking about recertification, you are talking about passing or failing. If you are talking about an educational self examination, there is immediate feedback, which evaluates the weaknesses, and the physician then can respond immediately to those weaknesses.

That is why I mentioned in our testimony our self-assessment program, which does that. It tells why the physician answered the question wrong, given plausible distractors, and it also gives a critique and references as to what is relevant scientifically.

Chairman STARK. But tell me this. To get into the practice to begin with from day one, somebody has to get a license someplace; right?

Dr. VISSCHER. Correct.

Chairman STARK. Let's say in New York State, I presume you have to do more than pass just a written test. What else do you have to do?

Dr. VISSCHER. In addition to passing the three levels of written examinations, that are offered by the National Board of Medical Examiners, you have to graduate from a medical school. That involves evaluation of that individual. You have to have postgraduate training at least 1 year. Most of the people, however, finish a residency. They have to be approved by their program director for graduation.

Chairman STARK. That residency is evaluated as part of the program. You don't get out of the residency if you don't do a good job, I presume.

Dr. VISSCHER. In our specialty, the resident program director has to credential that the individual has satisfactorily completed the residency training. And then with initial access then to licensing, you have more than a written examination.

In terms of certification, the best method is not only to give a written examination, but also a look at patient care experience. The suggestion you are proposing for just an examination to be recertified is not as valid as the initial opening hoops that physicians have to pass through.

Chairman STARK. Let me ask this, just as a practical matter: I could not go back today and pass freshman calculus or freshman chemistry at MIT, both because of atrophication and sophistication of the course level, and those two passed me some years ago.

Could your members in the American family practice just routinely go back and be relicensed, and if I could imagine, spend a week making rounds with a resident, which they might not have done for 15 years, and take those tests without studying at all?

Or would they really have to go back and do some boning up to pass the written tests, because they may have specialized somewhat more and forgotten two-thirds of the stuff because they don't use it in their practice?

Dr. GRAHAM. I believe the task for a family physician might be easier, but it would still be a very serious task, particularly to the extent that those three levels of examinations Dr. Visscher just re-

ferred to, we have our own basic biochemistry, physiology, anatomy, which most of us drift away from in the clinical practice, that would be most difficult.

If the examination was on clinical practice for a generalist as a family physician, an examination on general clinical practice is what they should be held competent for.

But that would not be a fair exam for a surgeon.

Chairman STARK. I am inclined to agree with you.

In other words, I don't think it would be any more reasonable than to ask me to go back and take college boards, which I think I took during World War II, because I don't think I could pass them today without spending an awful lot of time boning up on it. And I am not sure it makes any difference.

So I think what I can interpret in your answer is that it's not really relevant. It's relevant to testing how well somebody did in the initial education training, but it's not relative to a physician who has been in practice for a number of years and has developed either a specialized practice or a specialty.

Dr. VISSCHER. In obstetrics and gynecology, we also feel that it should be specialty specific. But let me tell you that our board, ABOG, uses a 150 question exam. One hundred of the questions are based on general obstetrics and gynecology. The other 50 questions can be chosen by the person who takes the exam from five other modules.

In other words, we are recognizing the need for specialty specific testing and are giving the physician the opportunity to choose the poison, so to speak.

We believe this method allows the physician to be examined in those areas in which he or she limits their practice.

Chairman STARK. That makes sense.

Dr. POPP. I would just amplify that a little bit. I think that if it's important for a physician to know something when he first gets out of training, it's equally important that he keep educated, continue his medical education and be able to pass a very similar examination later.

The older doctor should be just as good as the younger doctor. On the other hand, when we get away from the board process, which puts a tremendous amount of detail in each examination, it will be difficult to develop minimum standards for the people who are not certified.

Because in order to have someone tested in what he actually does, which is the only fair thing to do, it means a lot of segmentation of what the Secretary would have to develop. And that is going to very difficult. I think we shouldn't underestimate that task.

Chairman STARK. Are there any areas, I hate to even say countries, but I mean I am thinking of the military, of veterans, any particular areas where this kind of thing is done?

Is there any place in the world, in the industrialized world or in medicine as it may be practiced?

Dr. POPP. In the VA system one can be a physician working in the system fully credentialed. If you have a certificate you are given incentives.

Chairman STARK. Is there any State that requires it now? I appreciate your taking the time to help us through this. As you

know, it comes up. There is always the issue that is raised about quality. There are horror stories of those who ought to be disciplined. Where hard working members of PRO's are in trouble taking the disciplinary actions they want.

Secondly we are about to embark on a review of the whole question of malpractice and its causes. We are going to ask for your patience to lower their expectations. We are going to ask the trial lawyers to lower their expectations and we are going to ask the insurance companies to lower their expectations.

I think it is only fair that we ask the physicians to raise our expectations that we won't do things that are malpractice. One way is to try and weed out those who might do it. If we are going to get malpractice under control, we have to reduce the amount of errors that are made that arguable should not happen. Then we will deal in due time with far less comity than we have today with the trial lawyers who are not very happy about it at all.

Most of your patients see a little malpractice as a way to pay their children's graduate school tuition—and the insurance companies make a lot of money on it. You are the first ones called upon to help figure out a way to bear your share of the load. We will deal with the rest of it as we go through this problem.

I hope we can find ways to help you be more effective with the State licensing procedures.

Thank you very much for helping us today.

[Whereupon, at 3:58 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF RICHARD P. KUSSEROW
INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL

I appreciate this opportunity to submit a statement for the record on H.R. 4464, the "Medicare Physician Qualification Act of 1990."

While I agree with the general objectives of the proposed legislation and the need to take some Federal action in this area, I have some reservations about the suggested approach. Below, I set forth those reservations and suggest some alternative actions. In so doing, I draw on our recent studies concerning Peer Review Organizations, State medical boards, patient dumping, physician dispensing of drugs, and physician financial arrangements with other health care providers.

RESERVATIONS

My reservations about mandating the periodic certification of licensed physicians are threefold. First, I am concerned that the approach is not sufficiently targeted -- that it would not focus precisely enough on physicians whose competence or conduct presents a danger to the public. With resources to carry out oversight functions being scarce, I believe it is vital that they be used in a cost-effective way to zero in as directly as possible on problem cases.

Secondly, I am concerned that H.R. 4464 expects too much of an examination. I recognize that some important strides have been made in testing for practice skills. Yet, for many areas of medical practice, let alone personal conduct, an examination still can not provide adequate assurance of a physician's practice skills.

Thirdly, I am concerned that the bill does not address the disciplinary or educational interventions that can be taken by oversight bodies against physicians whose practice or conduct violates established laws. Such interventions, we have found, are a vital part of assuring the public of physicians' qualifications.

ALTERNATIVE APPROACHES

As an alternative approach, I urge that we identify ways of helping and encouraging State medical boards to become more effective in carrying out their licensure and discipline responsibilities. Under our Federal system of government, these boards have long had the primary role in protecting the public against incompetent or unprofessional physicians. While their effectiveness has been hampered by budgetary contraints and other factors, I believe that in various ways we can provide information and remove constraints that would enable the boards to perform more effectively and that would hold them more clearly accountable.

We will provide detailed information of this kind in two forthcoming reports. One, entitled "State Medical Boards and Medical Discipline," will be issued shortly. Another, entitled "Quality Assurance Activities of State Medical Boards," will be issued during the summer.

At this point, however, I can share two lines of activity that these reports will support. Both involve more focused oversight of physicians likely to present quality of care problems.

First, we suggest that Federal legislation be introduced that would mandate that the Medicare-funded Peer Review Organizations (PROs) share case-specific information with the State medical boards in all instances when they send a sanction notice to a physician. I am referring specifically to the Level III Quality Review cases specified under the third scope of work for the PROs. These are the most serious cases that emerge from the PROs' quality of care reviews. They involve medical mismanagement "with significant adverse effects on the patient."

Although all such cases would not necessarily result in disciplinary action by State boards, they would provide the boards with valuable information on a universe of physicians who may well have violated provisions of the State medical practice act.

In 1989, which for many PROs did not include a full year of operation under the third scope of work, there were about 600 Level III cases reported by the PROs. A second line of activity that we believe warrants some attention involves the use of random audits of physician practice. We learned that a number of Canadian provinces are taking this approach and find it to work quite successfully.

Under such an approach, the State boards might conduct on-site practice audits of a sample of physicians. Moreover, the sample might be limited to those physicians who are not certified by specialty organizations and are not on hospital medical staffs. For such physicians, the boards now serve by and large alone in protecting the public from improper medical care.

For physicians found through a practice audit to be functioning outside of commonly accepted standards, the board should be expected to intervene -- either through educationally focused corrective actions or, if necessary, through some kind of formal disciplinary action.

SUMMARY

In our forthcoming reports on State medical boards, we will document many of the limitations that still constrain the operations of the State medical boards. In those reports we will also offer further detail on the type of Federal actions that can be taken to help States address these limitations.

Our recommendations will be based on the assumption that the future Federal relationship with the State boards should be conducted more in terms of a partnership addressing joint concerns rather than one involving separate spheres of responsibility. Such a partnership could be quite effective in achieving the intent of the Medicare Physician Qualification Act of 1990.

STATEMENT OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. Chairman and members of the Subcommittee, I am pleased to submit for the record the following testimony concerning H.R. 4464, the "Medicare Physician Qualification Act of 1990."

The Academy wishes to commend you, Mr. Stark, for directing your attention to the quality of medical care received by Medicare beneficiaries. We share your commitment to the highest quality care; however, we believe that the measurement of quality should be accomplished in a way that builds on the current methodologies for assessing physician competence.

In 1986, the American Board of Orthopaedic Surgery adopted the policy of issuing time-limited certificates which require recertification of diplomates every ten years. In February of 1990, the fellowship of this Academy endorsed the concept of recertification as a method of determining the maintenance of adequate and appropriate current knowledge of orthopaedic surgery.

Certification or recertification by an ABMS Board is a high standard, well above a level of minimum qualification. Thus, we are pleased to see that your proposal identifies this as one mechanism for measuring competence.

Mr. Chairman, 17 of the 23 Boards now issue time-limited certificates which are valid for periods ranging from 7 to 10 years. Thus, your goal of having physicians periodically demonstrate their qualification as a condition for being granted the privilege of practicing medicine is being met by medical certifying Boards and national medical specialty societies without involvement outside the profession.

There are many innovative pathways under consideration by the ABMS and its member Boards for measuring clinical competence and knowledge. Because of this ongoing work, we are greatly concerned about the imposition of federal requirements for recertification and relicensure applicable only to Medicare beneficiaries.

This is an important but sensitive matter. As such, we encourage you to move forward only with the provision in H.R. 4464 which calls for the Physician Payment Review Commission to study current methods of assessing physician competence and for the Commission to submit a report recommending the types of evaluations that should be used and the organizations that should conduct the evaluations.

The Academy would welcome the opportunity to work with the Commission and this Subcommittee to explore various pathways for reaching our common goal.

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

I am Merwyn Bagan, M.D., a practicing neurosurgeon from Concord, New Hampshire. I speak for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent more than 3,200 neurosurgeons in the United States.

Mr. Chairman, in the absence of an ability to develop a valid, fair recertification or relicensure process, the continuing medical education method is our choice to promote competency. As neurosurgeons we seriously question the validity of a written exam as a determinate of competency.

Our specialty and the American Board of Neurological Surgery (ABNS) have taken the position that, based upon current testing methods, recertification on a periodic basis probably holds little validity. In particular, cognitive examinations, which contain multiple choice and true/false questions, etc., are not fully indicative of the quality of competency of a medical specialty practice. Other testing techniques which have been considered include an oral examination similar to that taken when a candidate was awarded a certificate as an ABNS Diplomate, practice reviews with audits of random charts at hospitals, on-site inspections, and investigations of problem cases provided by the various State Boards of Medical Licensure. All of these methods fall short of a careful, accurate assessment of the competency of a practicing neurosurgeon years after the primary certificate was issued. Until a reasonably accurate, valid, and fair system surfaces, the ABNS does not plan to institute a recertification process.

A number of American Board of Medical Specialties member Boards are interested in "outcome assessment". This mechanism for recertification would require some kind of on-site scrutiny of a neurosurgeon's practice and consideration of the type of practice. Thus, the individual who devotes most of their time to spine work would be tested or evaluated primarily as a spine surgeon with less emphasis on neurovascular problems. Neurosurgeons who spend virtually all of their time in pediatric neurosurgery would not be expected to have a comprehensive knowledge of and as excellent an outcome for patients who are not in that age group. This type of assessment has been used by the American Board of Obstetrics and Gynecology (ABOG), although only after a Diplomate's practice has been judged to be "marginal" by a directed multiple choice examination and brief oral exam given by ABOG Directors.

Despite the absence of a formal recertification process by the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we have a well organized Continuing Medical Education (CME) Program. The continuing education process for neurosurgeons is accomplished through multiple mechanisms. These include meetings of numerous neurosurgical organizations, special courses, publications and various self-assessment tests.

The neurosurgical community has strict CME requirements for its members. Both the AANS and the CNS require 90 hours of neurosurgical continuing education credit every three years for members to remain in good standing. This is irrespective of any state relicensure requirement. To assist the membership in meeting these criteria, numerous CME activities are made available to the members every year.

There are annual meetings of neurosurgical groups dedicated to the education of their particular membership. The two largest annual meetings are the CNS which meets in the fall and the AANS which meets in the spring. Each enrolls 800 to 1500 neurosurgeons for four days of intensive education. In addition, subspecialty sections dealing with specific areas in neurosurgery meet during the AANS and CNS Annual Meetings. These are the

Joint Sections on Neurotrauma and Critical Care, Tumors, , Cerebrovascular Surgery, Pain, Disorders of the Spine and Peripheral Nerves, Pediatric Neurological Surgery and Functional and Stereotactic Surgery. Some of the sections also have independent scientific meetings.

In addition, there are five smaller neurosurgical groups which have regular meetings: The Society of Neurological Surgeons which gathers about 100 leading surgeons for discussion and presentation of issues relevant to teaching in neurosurgery; The Academy of Neurological Surgeons which reviews the entire range of new trends in clinical and investigative work; The Society of University Neurosurgeons which involves itself especially with work of academic importance; The Neurosurgical Society of America which emphasizes new developments in the clinical areas; and The Research Society of Neurosurgeons which acts as a forum for young investigators.

Regional neurosurgical societies meet several times a year and have scientific sessions. The regional groups are the New England Neurosurgical Society, the Southern Neurosurgical Society, the Western Neurosurgical Society and the Rocky Mountain Neurosurgical Society. The numerous state neurosurgical societies, which usually meet annually, have scientific sessions.

Annual postgraduate courses in neurosurgery are given in New York City, Boston, Chicago, and San Francisco. Additional courses may focus on particular aspects of spinal, cerebrovascular, and stereotactic surgery.

Finally, there are sessions which are offered by other public and private groups that are important to our training and, therefore, are approved for continuing medical education credit. These include courses in neurology, vascular disease, risk management, ethics, and new technology such as the laser or spinal instrumentation.

A wide range of publications are distributed to the entire membership of the AANS and CNS as part of the continuing education process:

- A series called "Concepts in Neurological Surgery"
- Scientific papers of the CNS Annual Meeting are published in a bound Proceedings volume.
- Neurosurgery, the official journal of the CNS, is published monthly.
- The Journal of Neurosurgery, the official journal of the AANS, is published monthly.
- Surgical Neurology, is a journal published monthly.
- The AANS has commenced publication of a series of books on neurosurgical topics.
- Three self-assessment continuing education vehicles are: "Contemporary Neurosurgery", " Neurosurgical Consultants", and "Update in Neurology and Neurosurgery"
- There is a videotape library with the latest surgical techniques at the CNS in addition to the "Video Journal of Neurosurgery."
- Self-Assessment in Neurological Surgery (SANS), a test rewritten every four years, provides neurosurgeons with an up-to-the-minute review of their practice.
- Symposia on particular topics are published by Raven Press as Seminars in Neurological Surgery. Titles thus far include Pediatric Neurological Surgery, Spinal Deformities and Neurological Dysfunction, Surgery of the Posterior Fossa, Neural Trauma, Cervical Spondylosis, and Clinical Management of Pituitary Disorders.

The umbrella group for CME is the Joint Committee on Education (JCE) which was established in 1975 by the AANS and CNS for

the fundamental purpose of encouraging and promoting continuing education in neurological surgery. The mission of the Committee is to assure the highest educational standards for neurological surgery with the purpose of fostering excellence in health care for all patients with diseases of the nervous system.

The JCE coordinates five major modalities for CME in neurosurgery: (1) directly sponsored courses and meetings where they are appropriate; (2) a self-assessment test for neurosurgeons (SANS); (3) books published in areas not covered in the literature; (4) brochurus and educational material for non-neurosurgeons; and (5) joint sponsorship for relevant courses.

The incompetent or impaired physician is a complicated social and professional problem. We do not believe a written exam necessarily will address appropriately, or indeed, solve the problem. CME may not be the ultimate solution to the problem. There are several mechanisms being developed and/or refined beyond CME which suggest that in time a process can be designed which will assure consumer protection. First, is the development of practice guidelines. Second, peer review evaluations are becoming more sophisticated and will be enhanced greatly by practice guidelines. Third, certain states are developing quality assurance programs for the expressed purpose of recredentialing. For example, New York has an Advisory Committee on Physician Recredentialing with whom our New York State Neurosurgical Society is discussing the specifics of an appropriate review. New York may develop a model program that other states could implement. Fourth, the federal government is making progress in the implementation of the Health Care Quality Improvement Act.

The key word in the above stated competency programs is developing. We think it is premature to enact national legislation. Your Committee has placed the medical community on notice. Now time must be allowed for all interested parties, from the state licensure boards to the American Board of Medical Specialties (ABMS), to achieve a mechanism that meets the criteria of fairness, appropriate methodology, and sufficient flexibility to allow for the great differences between specialties and sub-specialties.

It might be appropriate for the Committee to engage the Institute of Medicine IOM) to continue its previous research with a directive to recommend specific licensure or recertification testing methodologies. We presume the IOM would call upon members of the ABMS to cooperate in the effort. In addition, the National Association of Attorneys General could be asked to develop a model relicensure statute.

Mr. Chairman, we are members of the ABMS and will continue to work with our colleagues to explore and develop a recertification process.

We are developing practice guidelines and working with the new Agency for Health Care Policy and Research to assure our guidelines complement its model.

As mentioned above, our New York State Neurosurgical Society is discussing the specifics on recredentialing.

We also are prepared to work with the subcommittee to achieve the laudatory goals of H.R. 4464.

Thank you.

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April 23, 1990

Honorable Pete Stark, Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Stark:

While the College wants to commend you and support you in your efforts to legislate mandatory certification of all physicians, we would appreciate an opportunity to more formally appear before your subcommittee when you hold hearings on this bill. We also want to bring to your attention the fact that whereas at the present time physicians' licensure is a prerogative of the States, our organization is seeking ways and means of changing that in order to ensure parity and equity in the reciprocal licensure of physicians whose final medical degrees were conferred by international (non-domestic) medical schools but whose training and primary licensure to practice medicine were provided by United States medical institutions and the States, respectively.

Based on your press release on March 29, 1990, I am writing to let you know about some of our concerns: general as well as specific. They are as follows:

1. Since not all physicians are board certified, nor is there such a requirement for them to do so in order for them to practice their respective specialties, would not a mandatory re-certification of "specialists" alone impose a hardship on those who have taken the trouble of obtaining specialist status? Secondly, would not such a requirement discourage physicians from voluntarily taking the specialist examinations?

2. We believe that seeking specialty board certification must remain as a voluntary option for physicians as it is simply not a practical measure to insist that all practicing physicians become certified as specialists.

3. Legislation affecting the present voluntary nature of seeking specialist training and status may very well drive out of our rural and urban communities the thousands of general practitioners who provide primary and secondary care to our rural and inner city citizens at affordable costs. Perhaps a GAC study of your bill's impact on this matter should be considered concomitantly as you proceed with your legislative efforts.

4. We believe that professions such as law, nursing, pharmacy, psychology, dentistry, engineering, etc., must also be subject to re-licensure just as physicians are being required to by the States. Selective targeting of physicians alone to demonstrate exemplary professional conduct while no such requirements are made of lawyers (for example) is unfair and not in keeping with the spirit of our democracy.

The College would appreciate an opportunity as an invited witness to speak further on these issues as and when hearings on your bill are held. We thank you for your consideration.

Sincerely,

Kishore J. Thampy

Kishore J. Thampy, MD, FACIP, President
American College of International Physicians

cc: Drs. Alexander, Chieu, Bofill and Yadao

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

RE: Physician Relicensure or Recertification

May 7, 1990

The American Medical Association is pleased to have this opportunity to submit a statement for the April 23, 1990 hearing record regarding proposed legislation (H.R. 4464) which would require physicians receiving Medicare reimbursement to pass an examination as to their competency every seven years. The expressed intent of this legislation is to ensure that Medicare beneficiaries receive medical services only from competent physicians. The AMA shares the concern with Representative Stark and others that physicians who have "lost their skills or failed to keep up with modern medical practice" may still be providing medical services. Physician competency and the quality and methods of continuing medical education have long been a concern of the AMA and AMA's involvement in assuring the quality of undergraduate, graduate and continuing medical education and accreditation is clearly demonstrating the profession's commitment to quality assurance. The vast majority of physicians are highly qualified professionals. In light of the medical professions success in maintaining both individual and collective standards of high quality, we believe a federal mandate for physician relicensure or recertification, as would be established by H.R. 4464, would not ensure physician competency and would create an expensive and intrusive bureaucracy. Federal mandatory relicensure or recertification would prove to be an expensive program with minimal effectiveness, and with little incentive for continuing medical education.

Although we do not believe a great number of physicians would be so unprofessional, one possible result of the proposed legislation might be a new market for weekend seminar courses in which physicians for a fee could prepare for the relicensure or recertification. We do not believe that this would be the proper mechanism to educate physicians on advances and innovations in their area of medicine. Many more effective methods of providing the physician with continuing medical education are available and routinely used by the many physicians who are working to enhance their abilities.

Licensing Boards

All licensing jurisdictions require periodic reregistration of licenses to practice medicine. The purposes of reregistration are to maintain an accurate list of physicians practicing within the jurisdiction, and to provide physicians with opportunities to indicate whether they are still engaged in the practice of medicine, whether they have new addresses, and, increasingly, to provide boards with the opportunity to assess the physician's continued competence to practice.

Licensing boards have increased the reporting requirements for reregistration. For instance, 21 boards at present require physicians to report whether they have undertaken continuing medical education during the interval between reregistrations. The Federation of State Medical Boards "Report of FLEX and Licensing Requirements" (1989-1990 Exchange, Section. I) indicates that 39 of the 54 licensing jurisdictions at present require some kind of a report at reregistration. More and more frequently the reports are related to practice questions. For instance, 27 boards require a report as to whether a disciplinary action of some kind has been taken against the physician by another licensing jurisdiction, and 23 boards require a report as to whether an organized hospital staff has taken action restricting the scope of the physician's practice.

Licensure of professionals, including physicians, has traditionally been a state responsibility. State licensing boards are better equipped than the federal government to determine a physician's competency to practice medicine and how that competency should be demonstrated.

In addition, a recertification written examination is now required by 16 of the 23 medical specialty boards*, with all moving in that direction. This, coupled with quality continuing medical education, would better ensure that a physician is up to date in the area of medicine in which he or she practices.

Licensing boards are requiring that physicians, hospital staff and insurance companies report matters that reflect adversely on a physician's competence. The Federation of State Medical Boards (FSMB) recently suggested that licensing boards collect information about the following:

- adverse actions by other licensing jurisdictions;
- adverse peer review findings or adverse hospital staff actions;
- adverse actions taken by professional medical societies, law enforcement agencies or associations;
- court or governmental agency actions related to conduct described in the medical practice act;
- an adverse judgment in a liability case;
- voluntary surrender or voluntary limitation of a license;
- denial of a license by another jurisdiction;
- voluntary resignation or restriction of hospital privileges while under investigation by the hospital staff;
- resignation or withdrawal from a medical society, while under investigation by the society;
- treatment for addiction; and
- indications of physical or mental disability that impacts on the ability to treat patients.

The FSMB describes this inventory as "markers." The use of markers by licensing boards is called "evaluative reregistration." Some of the markers do not in themselves justify action against a physician's license. Several of them taken together would, in the FSMB's view, justify an inquiry into a physician's medical competence or professional conduct. These reports might logically lead a board to warn a physician, or to require a period of remedial education, an examination of medical knowledge, or an audit of practice.

Except where there is a reason to believe that a physician's knowledge of medicine is deficient, the AMA opposes the use of mandatory cognitive examinations of medical knowledge at the time of reregistration. The most effective mechanism to assure competency is through peer review. Where a physician is not subject to peer review, such as a recent medical school graduate, alternate mechanisms to evaluate the competency are appropriate.

*The specialty boards with a recertification written examination required are the American Board of: Allergy and Immunology, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Nuclear Medicine, Obstetrics/Gynecology, Opthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Surgery, Thoracic Surgery, and Urology. The specialty boards without a recertification written examination required are the American Board of: Anesthesiology, Colon and Rectal Surgery, Neurological Surgery, Plastic Surgery, Preventive Medicine, Psychiatry and Neurology, and Radiology.

Examinations of medical knowledge are appropriate for medical graduates at the time of graduation, since they are an indication that the graduates have a general knowledge of the field of medicine sufficient for entry to practice. After they begin to practice, most physicians are subjected to peer review. For instance, the clinical practice of a physician working in a hospital is routinely reviewed by peers. It is more difficult to assess the practice of physicians who do not have hospital staff appointments and, consequently, do not have regular opportunities for practice assessments.

Risk Management Programs

The AMA is involved in a project that should demonstrate one mechanism of providing an effective and practical means of demonstrating the competence of this group of physicians.

A pilot risk management project in the State of Oregon (AMA/Specialty Society Medical Liability Project) should help ensure that physicians meet minimum standards of competency. The three components of this risk management program are:

1) Office Self-Assessment Survey

The Office Self-Assessment Survey is designed to help physicians inventory the non-clinical aspects of their practice. Participants receive a report comparing their responses to those of their colleagues in the same specialty and with the same office type so they can see how they "stack up." It is expected that they will thus notice aspects of their practice that deserve attention and modification.

2) Self-Study Course

The goal of the self-study course is for physicians to explore how certain practice and behavior deficiencies (many of which are alluded to in the Self-Assessment Survey) operate to expose physicians to medical malpractice claims. The participant essentially peer-reviews a series of five "Physician Practice Review" packets, each containing a specialty-specific physician profile with claim abstracts and related documents, all based on actual physicians and claims. Completion of the course includes having the participant comment upon those practice and behavior patterns in his/her own practice which may be similar to those of the physician just reviewed.

3) In-Office Survey

The in-office survey is intended to uncover any problems that remain after the first two segments of the program have been completed so that appropriate action can be initiated if necessary. A physician and a clinic manager survey the practice and give direct feedback at the conclusion of the half-day visit. Information from the Office Self-Assessment Survey and the Self-Study Course may also be presented and discussed.

This project, refined and enlarged, will provide a means to collect national, cross-specialty data on the effectiveness of loss prevention efforts. These data will allow physicians to educate themselves on methods of improving the quality of the medical services offered in their practice.

Quality Assurance

Recertification or relicensure does not improve patient care or the quality of medical services provided by a physician. A more productive approach is through voluntary continuing medical education. Recently enacted legislation in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) recognizes this and has established a federal Agency for Health Care Policy and Research. This Agency's mission is to enhance the quality, appropriateness and effectiveness of health care services as well as access to these services. This mission is to be accomplished through a broad base of scientific research and promotion of improvements in clinical practice and in the organization for financing and delivery of health care services.

In addition, this new Agency shall establish an "Office for the Forum for Quality and Effectiveness in Health Care" which will be responsible for the development and periodic review and updating of clinically relevant guidelines that may be used in determining how diseases, disorders and other health care conditions can most effectively and appropriately be prevented, diagnosed, treated and managed clinically. This Agency will provide physicians with up-to-date information that can be utilized in improving the quality of the medical services provided to their patients.

The OBRA-89 legislation also created an Advisory Council for Health Care Policy Research and Evaluation that will advise the Department of Health and Human Services as to recommendations for priorities for a national agenda and strategy for the conduct of research, demonstration projects and evaluations with respect to health care, the development and application of appropriate health care technology assessments, the development and periodic review and updating of guidelines, standards, performance measures and medical review criteria, and the conduct of research outcomes of health care services and procedures.

With respect to the Medicare program, OBRA-89 requires that the Secretary, through the HCFA Administrator, conduct and support research with respect to outcomes, effectiveness, and appropriateness of health care services and procedures and to assure that the needs and priorities of the Medicare program are appropriately reflected in the development and periodic review and updating of treatment-specific or condition-specific practice guidelines. The Secretary shall conduct or support evaluations of the comparative effects on health and functional capacity of alternative services and procedures used in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

By January 1, 1991, initial guidelines will be developed. These shall include guidelines on at least three clinical treatments or conditions that account for a significant portion of Medicare expenditures and have a significant variation in the frequency or the type of treatment provided or otherwise meet the needs and priorities of the Medicare program as set forth by the Administrator of HCFA.

The Institute of Medicine (IOM), in its 1990 report "Medicare: A Strategy for Quality Assurance," stated that the nation is perceived to have a "solid, admirable base of good quality health care." In contrast, the IOM found that there are some areas of deficiencies: overuse of unnecessary services and inappropriate services; underuse of needed services; and poor technical skills, interpersonal care, or judgement in the delivery of appropriate services.

On the basis of these findings and conclusions, the IOM outlined its vision of a quality assurance system for Medicare. It focuses on health care decision making and health outcomes for Medicare beneficiaries, enhanced professional responsibility and capacity for improving care, use of clinical practice as a source of information to improve quality of care to improve the health of the elderly population. The IOM believes that this "ideal" system would build effectively on the existing quality assurance system, but would change the existing structure to avoid heavy reliance on provider-oriented process measures, existing regulation (state and federal), and external monitoring. The added use of the IOM process would contribute new clinical knowledge to improve the quality of care and improve the health of the elderly.

The AMA believes that all of this information will be useful to the physicians in their treatments of all patients, not just Medicare beneficiaries. Congress, in its concern for physician competency, has already enacted several provisions designed to improve the knowledge of the individual physician on a continuing medical education basis -- not on a federal testing for relicensure or recertification basis. With the burgeoning growth in medical knowledge and ability, such education needs to be encouraged. A federal relicensure or recertification test is not an effective tool to determine whether the knowledge is both present and used.

Practice Parameters

In recent years, the role of practice parameters in guiding clinical decision making, improving quality and assuring appropriate utilization of health care services has received considerable attention. Practice parameters are strategies for patient management developed by the profession to assist physicians in clinical decision making. Forms of practice parameters include practice guidelines, clinical standards, technology assessments, and technical advisories.

Effective practice parameters can be expected to guide physicians' practices leading to substantial benefits for patients. For example, cardiac pacemaker implantation parameters developed by the American College of Cardiology have contributed to a significant improvement in the appropriate utilization of cardiac pacemakers. Also, implementation of parameters for intraoperative monitoring developed by the American Society of Anesthesiologists has significantly reduced the occurrence of hypoxic injury in patients during surgery.

As evidence showing the usefulness of practice parameters has grown, physician organizations have expanded their efforts to develop practice parameters. In the early 1980's, only eight physician organizations had developed practice parameters; today, 26 physician organizations have followed this example, resulting in over 700 practice parameters. At least 10 additional organizations are now in the process of parameter development.

To facilitate the use of parameters, the American Medical Association (AMA) recently published a listing of available practice parameters, and has also completed a monograph which addresses legal issues with regard to their development and use.

The AMA's primary objective for practice parameters is to ensure that parameters are properly developed and implemented so that patients receive appropriate, effective, and necessary medical care. To accomplish this goal, the AMA's efforts are directed primarily toward working cooperatively with other physician organizations to facilitate their development of practice parameters. To this end, the AMA and the national specialty societies have formed two groups: the AMA/Specialty Society Practice Parameters Partnership, and the AMA/Specialty Society Practice Parameters Forum. The mission of the Partnership is to guide and coordinate the activities of organized medicine in the development, evaluation and implementation of practice parameters. The Forum is to provide an arena for specialty societies to share information and address common problems with regard to developing parameters. Forum meetings have focused on a broad array of complex issues involved in the development of practice parameters. In cooperation with the AMA/Specialty Society Practice Parameters Partnership, the AMA recently produced a report--Attributes to Guide the Development of Practice Parameters.

The AMA House of Delegates, which includes representatives of physicians in all 50 states and 79 specialty societies, firmly supports the development of practice parameters. The AMA also has adopted the policy that practice parameters meeting accepted principles should be used as a foundation for developing and modifying quality assurance programs, utilization review systems, and insurance coverage policies.

Many health care review organizations have developed review criteria, often without adequate input from physicians or physician organizations. At times, review criteria from one organization conflict with those from another. Practice parameters developed by physician organizations can be expected to provide a logical basis for the development of uniform review criteria and a solid foundation for assessment of medical care and quality assurance activities.

Properly utilized by quality assurance and other review programs, practice parameters can identify those medical services which should be appropriate and those which may require additional and more in-depth review. In most circumstances, variations from parameters should constitute only a signal for further peer review. However, in some circumstances, parameters may specify that certain services are deemed by the preponderance of medical opinion to be inappropriate in virtually any clinical situation.

Quality assurance (QA) programs can look to practice parameters as a foundation for effective QA review and a powerful mechanism to improve medical practice. Physicians can be expected to be responsive to scientifically sound, clinically relevant practice parameters.

The National Practitioner Data Bank

Another recent innovation to monitor physician competency is the National Practitioner Data Bank (Data Bank). The Data Bank, mandated by the Health Care Quality Improvement Act of 1986 (P.L. 99-660), is scheduled to open this Spring. In addition to providing limited immunity for good faith peer review activities, the law created the Data Bank to collect and release certain information relating to the professional competence and conduct of physicians, dentists and other health care practitioners.

The AMA supports the intent of the law, which is to encourage peer review and protect the public from incompetent practitioners. However, since 1986, the Data Bank activity has grown from a "flagging" mechanism to an immense data collection project which will, within two years of the date it opens, amass data on every physician with hospital privileges in the United States.

The Data Bank will contain the following information:

1. Reporting Medical Malpractice Payments

   Each person or entity, including an insurance company, which makes a payment on behalf of any licensed health care practitioner as the result of a claim or a judgement must report information to the Data Bank and to the appropriate State licensing board.

   Persons or entities must submit information to the Data Bank and simultaneously to the State licensing board within 30 days from the date that a payment is made.

   Any person or entity that fails to report information on a payment required to be reported is subject to a civil money penalty of up to $10,000 for each such payment involved.

2. Reporting Licensure Actions Taken by Boards of Medical Examiners

   Each Board of Medical Examiners must report to the Data Bank any action based on reasons relating to a physician's or dentist's professional competence or professional conduct.

   The Board must submit information within 30 days from the date the licensure action was taken.

   If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board has failed to submit a report as required, the Secretary will designate another qualified entity for the reporting of information to the Data Bank.

3. Reporting Adverse Actions on Clinical Privileges by Hospitals

   Each hospital must report to the Board of Medical Examiners the following actions.

   - any professional review action, based on the professional competence or professional conduct which affects or could affect adversely the health or welfare of a patient or patients, that results in revocation, suspension, limitation, or reduction of the clinical privileges of a physician or dentist for a period longer than 30 days; and

   - acceptance of the surrender of clinical privileges or any restriction of such privilege by a physician or dentist if under investigation by the hospital relating to possible incompetence or improper professional conduct or in return for not conducting such an investigation or proceeding.

The hospital must report an adverse action to the Board of Medical Examiners within 15 days from the date the adverse action was taken. The Board of Medical Examiners must submit the information received from the hospital within 15 days from the date on which it received this information.

The hospital may report to the Board of Medical Examiners adverse actions on clinical privileges of other health care practitioners.

If a hospital substantially fails to report information in accordance with the regulations, the immunity protections provided under the Health Care Quality Improvement Act will not apply to the hospital for professional review activities that occur during the three year period beginning 30 days after the date of publication of the hospital's name in the Federal Register.

Each hospital, either directly or through an authorized agent, must request information from the Data Bank when a physician, dentist or other health care practitioner applies for medical staff membership or clinical privileges and every two years for every physician, dentist or health care practitioner who is on its medical staff or has clinical privileges.

The following entities also have access to the Data Bank:

- state licensing boards;
- health care entities which have entered or may be entering employment or affiliation relationships with a health care practitioner who has applied for clinical privileges or appointment to the medical staff;
- a health care entity with respect to professional review activity;
- an attorney who has filed a professional liability action or claim against a hospital may query the Data Bank for information regarding a specific practitioner who is also named in the action. However, this information will only be disclosed if the attorney submits evidence that the hospital failed to request information from the Data Bank as required by law, and the information may be used solely with respect to the professional liability action against the hospital; and
- individual practitioners may have access to their own Data Bank records upon request.

The information contained in the Data Bank is confidential and intended for authorized entities only. Any person who violates the confidentiality provisions shall be subject to a civil penalty of up to $10,000 for each violation.

All persons/entities requesting information, except the practitioner requesting his/her own record, will be charged a fee. The fee is yet to be set by the government, but is planned to be nominal.

Thus, the Data Bank will be a resource used to compile information as to physician competency. We believe that this is another tool which would provide a better basis to judge an individual physician's competency than would a federal relicensure or recertification test taken every seven years.

Conclusion

A relicensure or recertification program for physicians, as would be established by H.R. 4464, will not address the specific components which make up physician competency. A program to test hundreds of thousands of physicians in order to identify a few aberrant practitioners is not a good use of the government's or the profession's resources. Rather, the program should concentrate on identifying problem practitioners based on identifiable quality problems. Programs already underway better identify

and provide the physician with the self-evaluation and knowledge necessary to keep the physician up-to-date on the latest medical innovations and skills. No federal relicensure or recertification program can provide this information or education to the physician on a continuing basis.

The AMA urges the Committee to join us in opposing H.R. 4464. This bill cannot guarantee competence, and it would impose a substantial and unnecessary burden on the federal government.

5410p

STATEMENT OF DENNIS J. LYNCH, M.D., CHAIRMAN, GOVERNMENT RELATIONS COMMITTEE, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.

Mr. Chairman: The American Society of Plastic and Reconstructive Surgeons (ASPRS) is pleased to have the opportunity to provide its views on H.R.4464, the Medicare Physician Qualification Act of 1990.

We compliment the Chairman for addressing an area where ASPRS too has concerns. As recent Congressional hearings have illustrated, the problem of practitioners performing cosmetic surgery without the requisite skills or training has resulted in serious harm to the patient. This has been compounded by an "anything goes" regulatory environment at the FTC even though advertising has lured patients with promises of guaranteed results and false claims of medical qualifications. Our interest has centered on the Federal Trade Commission's enforcement practices against "false and deceptive" advertising and gone beyond Medicare recipients to the entire patient population.

In this process, we have had occasion to evaluate what the appropriate role for government must be. We have concluded that the federal government must walk a fine line between enforcement of matters properly within its purview, and intruding into areas better left to medicine. We believe that, in advertising, there is an appropriate role for regulation. Advertising must be limited whereever there is a clear incidence of the public being misled and harmed. This can be accomplished at the federal, state and local level. And, it is an area where government has consistently had responsibility. On the other hand, the measurement of physician qualifications has long been a primary element of medicine's self-policing function and not a government matter. Medicine's role, however, has been eroded in recent years, not because of disinterest within medicine but because government has imposed a chilling effect on self-regulation. It is an atmosphere of uncertainty that permeates this environment -- what is the civil exposure to the unqualified practitioner who has been disciplined? What are the government's antitrust interests? It is this element of the problem that demands the blame and deserves the attention.

We agree that steps must be taken to prevent the unqualified individual from practicing medicine. And, we believe attention must be given to a more pervasive problem -- physicians qualified in one area performing services in another area, outside their competency. Everyday, we see "graduates" of a weekend seminar receiving on-the-job-training in areas that take others years to acquire skill sufficient to protect the health and safety of the patient. Yet the answer lies in the traditional processes -- certification by the state medical board, satisfactory assurances that unqualified practitioners are being weeded out, and a clear effort by medicine to limit the practice of physicians to areas where they have the requisite skills and training.

ASPRS notes the change in this year's bill that incorporates state programs and non-written examinations. This is a step in the right direction. We do conclude however that your bill goes much too far in bringing the federal Department of Health and Human Services into the province of medicine itself. We urge that you exert your considerable influence behind more vigorous self-policing by the profession and that you help clear away the inappropriate constraints to our doing so.